StoneRidge Chiropractic

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ACKNOWLEDGMENT OF LIABILITY and ASSIGNMENT OF BENEFITS

The undersigned patient and/or responsible party, hereby acknowledges personal responsibility and liability for all medical services which are provided by StoneRidge Chiropractic. This personal obligation is not affected by any obligation of insurance companies to pay health care costs. If an insurance company pays, the payments shall be credited to your account. If no insurance payment is received, you are completely responsible to pay for all medical treatments. In addition to continuing personal responsibility, and in consideration of treatment rendered or to be rendered, the undersigned hereby assigns the physician or facility named the following rights, power and authority:

RELEASE OF INFORMATION: You are authorized to release and to permit the examination or copying of any of my medical records, x-rays, laboratory reports and the results of all tests of any type or character to such person(s) as the physician and/or facility deems appropriate.

ASSIGNMENT OF RIGHTS: You are assigned the exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company or other person or entity to the extent of your bill for total services, including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payments, and prosecute and receive penalties, interest, court costs, or other legally compensable amounts owed by an insurance company or other person or entity. I as the patient and/or responsible party, further agree to cooperate, provide information as needed and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request. The physician and/or facility is also assigned the exclusive, irrevocable right to request and receive from any insurance company or health care plan any information or supporting documentation concerning or touching upon the handling, calculation, processing, or payment of any claim.

DEMAND FOR PAYMENT: To any insurance company providing benefits of any kind to me/us for treatment rendered by the physician/facility named, you are hereby tendered demand to pay in full the bill for services rendered by the physician/facility named, following your receipt of such bill for services to the extent such bills are payable under the terms of my/our policy for benefits, less any amount which I/we owe personally which are not payable under the terms of our policy.

THIRD PARTY LIABILITY: If patient(s) treatments for injuries are the result of the negligence of any third party, then patient(s) grant a secured interest (lien) against any recovery from such third party(s) to the extent of the bills for treatment in favor of the physician/facility named.

STATUTE OF LIMITATIONS: Patient(s) waive the right to claim any Statute of Limitations regarding claims for services rendered or to be rendered by the physician/facility named.

TERMS AND ATTORNEY FEES: Net 30 days from the date of invoice unless otherwise indicated. A finance charge of 1.5% per month (annual percentage rate of 18%) of the unpaid balance may be added monthly, both pre-judgment and post-judgment. Should collection become necessary, the patient(s) agrees to pay an additional 50% collection fee and all legal fees of collection, with or without suit, including attorney fees and court costs for services rendered by the physician/facility named.

RETURNED CHECK DISCLAIMER: I/We agree to pay attorney's fees of $150.00, all court, filing fees and charges or commissions of fifty percent that may be assessed to us by any collection agency retained to pursue this matter. I/We further agree to pay interest at the rate of one and one-half percent per month (eighteen percent per year).

LIMITED POWER OF ATTORNEY: I hereby grant to the physician/facility named power of attorney to endorse my name upon any checks, drafts, or other negotiable instrument representing payment from any insurance company, representing payment for treatment and health care rendered by the physician/facility. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my/our account or forwarded to my/our address upon request in writing to the physician/facility named.

In the event that any provision of this Agreement is determined to be invalid or unenforceable, all other provisions of this Agreement shall remain enforceable.

A PHOTOCOPY OF THIS INSTRUMENT SHALL SERVICE AS ORIGINAL.

Signature of Patient or Responsible party:

Signature Date SS#

Print Name Address