Austin Wellness Chiropractic Center
Katie Greeley DC, CACCP
Doctor of Chiropractic and Pediatric Certified
10815 RR 2222 Bldg3C suite #100
Austin, Tx. 78730
512-234-1868

Assignment of Benefits:

Assignment of Cause of Action: Contractual Lien

The undersigned patient or responsible party, in addition to continuing personal responsibility, and in consideration of treatment rendered or to be rendered assigns to Katie Greeley, DC, CACCP, the following rights, power, and authority:

RELEASE OF INFORMATION: You are authorized to release information concerning my condition and treatment to my insurance company, attorney, or insurance adjuster for purposes of processing my claim for benefits and payment of services rendered to me.

IRREVOCABLE ASSIGNMENT OF RIGHTS: You are assigned the exclusive, irrevocable right to any cause of action that exist in my favor against any insurance company for the terms of the policy, including the payment, and prosecute and receive penalties, interest, court loss, or other legally compensable amounts owned by an insurance company in accordance with Article 21.55 of the Texas Insurance Code to cooperate, provide information as needed, and appear as needed, whenever to assist in the prosecution of such claims for benefits upon request.

DEMAND FOR PAYMENT: To any insurance company providing benefits of any kind to me/us for the treatment rendered by Katie Greeley, DC, CACCP/Austin Wellness Chiropractic Center, you are hereby tendered demand to pay in full the bill for services rendered by Katie Greeley, DC, CACCP/Austin Wellness Chiropractic Center within 30 days following your receipt of such bill for services to the extent such bills are payable under the terms of the policy. This demand specifically conforms to Article 21.55 of the Texas Insurance Code, providing for attorney fees, 18% penalty, court cost, and interest from judgment, upon violation. I further instruct the provider to make all checks payable to 10815 RR 2222 Bldg 3C-100 Austin, Tx. 78730

STATUE OF LIMITATIONS: I waive my rights to claim any statute of limitations regarding claims for services rendered or to be rendered by Katie Greeley, DC, CACCP/Austin Wellness Chiropractic Center, in addition to reasonable cost of collections, including attorney fees and court cost uncured.

LIMITED POWERS OF ATTORNEY: I hereby grant to Katie Greeley, DC, CACCP/Austin Wellness Chiropractic Center the power to endorse my name upon any checks, drafts, or other

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negotiable instrument representing payment from any insurance representing for treatment and healthcare rendered by Katie Greeley, DC, CACCP/Austin Wellness Chiropractic Center. 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 in writing to Katie Greeley, DC, CACCP/Austin Wellness Chiropractic Center.

REJECTION IN WRITING: I hereby authorize Katie Greeley, DC, CACCP/Austin Wellness Chiropractic Center to establish a PIP or UM claim on my behalf. I also instruct my insurance carrier to provide said rejections in a timely manner. I acknowledge that I am entitled to minimum levels of coverage, as per section 1952.152 of the Texas Insurance Code, and further instruct my carrier to pay up to the available limits directly to physician/facility named above and send any and all checks or financial instruments to Austin Wellness Chiropractic Center, 1420 Cypress Creek Rd #200-190 Cedar Park, Tx 78613.

TERMINATION OF CARE: I hereby acknowledge and understand that if I do not keep appointments as recommended to me by my caring doctor at Austin Wellness Chiropractic Center, He/She has full and complete right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time. If during the course of my care, my insurance company requires me to take an examination from any other doctor, I will notify this physician/facility immediately. I understand that failure to do so may jeopardize my case.

The undersigned being attorney of record or authorized representative of insurance carrier for the above patient does hereby agree to observe all the terms above and agrees to withhold such sums from any settlement, judgement, or verdict as may be necessary to adequately protect said doctor above names.

Patient's Name Printed _____ Date: _____

Patient's Signature: _____ Date: _____

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PATIENT RECORDS AND DOCTOR LIEN

To: Attorney/Insurance Carrier

_____

_____

_____

I Do hereby authorize Austin Wellness Chiropractic Center to furnish you, my attorney/insurance carrier, with a full report of the examination, diagnosis, treatment, prognosis, etc. of myself in regard to the accident/illness which occurred/began on

_____

I hereby authorize and direct you, my attorney/insurance carrier, to pay directly to said doctor such sums as may be due and owing the office for medical services rendered me by reason of this accident/illness and to withhold such sums from any settlement, judgement or verdict as may be necessary to adequately protect said doctor. I hereby further give a lien on any settlement, judgement or verdict which may be paid to you, my attorney/insurance carrier, or myself as the result of the injury/illness for which I have been treated or injuries/illness in connection therewith.

Patient's Name Printed _____ Date: _____

Patient's Signature: _____ Date: _____

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AUTOMOBILE ACCIDENT PROTOCOL

Austin Wellness Chiropractic Center will accept assignment of your claim and submit your claim to your insurance company if the following criteria have been met within 1 week (7 days) of your initial visit to our office.

However, if after 7 days, if these requests are not all met for any reason, any outstanding balance becomes
due in full and the cost of future care is due at the time of service, until other arrangements are made with

The accident must be reported to the auto insurance company. They will provide you with their own personal injury protection (PIP) form which must be completed and returned to them.

The PIP form must be submitted to the auto insurance company within one (1) week from your initial office visit. We will be verifying receipt with the insurance carrier.

The name, address, and phone number of the insurance carrier for the vehicle that you were in as well as the policy holder's name if other than your own must be on file with our office.

The name of the person handling your claim (adjustor) and the claim number must be on file with our office.

A copy of your health insurance card must be provided (even if you think we already have one on file).

If you do not have health insurance, please sign a health affidavit. Your insurance company may require it to be notarized.

The name, address, and phone number of your attorney, if applicable must be provided to our office.

If for any reason the insurance company denies payment of your chiropractic bills, even though all of our office criteria have been met, you are ultimately responsible for the payment of these bills.

I HAVE READ THE ABOVE AND AGREE TO ALL THE TERMS OF THIS STATEMENT.

Signature: _____ Date: _____