

TEXAS BACK CARE
Dr. Carl M. Naehritz III, D.C. & Assoc.
2900 HIGHWAY 121, STE. 120
BEDFORD, TX 76021
(817) 545-1100 FAX (817) 545-1101

ASSIGNMENT OF BENEFITS

The undersigned patient and/or responsible party, in addition to continuing personal responsibility, and in consideration of treatment rendered or to be rendered assigns to the physician or facility named above 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: This shall apply to all monetary proceeds from any third party liability insurance policy and/or all monetary proceeds from any PIP/Medical payments insurance policy to which I am entitled, and from which I am to be paid in the form of an insurance settlement(s), claims(s), judgments(s), or verdict(s) resulting from the above identified accident (collectively the "insurance proceeds"). You are assigned the exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company for the terms of the policy, including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payment, and prosecute and receive penalties, court costs, or other legally compensable amounts owned by an insurance company, in accordance with **Code 542.051 to 542.061** of the Texas Insurance code or other applicable insurance or state statute. 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.

DEMAND FOR PAYMENT: To any insurance company providing benefits of any kind to me/us for treatment rendered by the physician/facility named above, you are hereby tendered demand to pay in full the bill for services rendered by the physician/facility named above **within 60 days** (electronic/paper) following your receipt of such bill for services to the extent such bills are payable under the terms of demand specifically conforms with **Code 542.051 to 542.061** of the Texas Insurance Code, providing for attorney fees, **18% penalty**, court cost, and interest from judgment, upon violation.

THIRD PARTY LIABILITY: If my injuries are the results of negligence from a third party, then I instruct the liability carrier to cut a separate draft to pay in full all services rendered, payable directly to the physician/facility named above.

STATUTE OF LIMITATIONS: I waive my rights to claim any Statute of Limitations regarding claims for services rendered or to be rendered by the physician/facility named

above, in addition to reasonable costs of collection, including attorney fees and court costs if incurred.

LIMITED POWER OF ATTORNEY: I hereby grant to the physician/facility named above the power 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 will be credited to my/our account or forwarded to my/our address upon request in writing to the physician/facility named above.

TERMINATION OF CARE WAIVER: I hereby acknowledge and understand that if I do not keep appointment as recommended to me by my caring doctor at this chiropractic clinic, 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.

This Lien, Assignment of Benefits and/or Subrogation Interest can not be revoked or modified with out the written consent of Dr. Carl M. Naehritz III, D.C.

A photocopy of this instrument shall serve as original.

Signature of Patient and/or responsible parties:

- 1. _____ Date _____
- 2. _____ Date _____

Before me this day personally appeared the person(s) whose signature(s) appear above, who by me being duly sworn upon oath say(s) that the statements set forth above are true and correct. Subscribed and sworn before me this ____ day of _____, 20__.

Notary Public _____ County, Texas.

My commission expires on _____

NOTARY PUBLIC