AUTHORIZATION, ASSIGNMENT & RELEASE FORM

AUTHORIZATION AND ASSIGNMENT

In consideration of undertaking to care for me, I agree to the following:

1. I authorize Hockessin Chiropractic Centre, P.A., herein after referred to as "HCC", to use my name on any and all claims or documents that relate to health insurance benefits due me.
2. "HCC" is authorized to release any information "HCC" deems appropriate concerning my physical condition to any insurance company, attorney or adjustor in order to process any claim for reimbursement of charges incurred.
3. I authorize direct payment to "HCC" of any sum I now or hereafter owe "HCC", by my insurance company or attorney, out of the proceeds of any settlement of my case and/or by any insurance company obligated to make payment to me or "HCC" based in whole or in part upon the charges made for services provided to me by "HCC"..
4. In the event of any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for services provided by "HCC" refuses to make such payment upon demand, I hereby assign and transfer to "HCC" the cause of action that exists in my favor against any such company (the name of which is believed to be correctly set forth under pertinent data) and authorize "HCC" to prosecute said action in my name as seen fit and further authorize "HCC" to compromise, settle or otherwise resolve said claim as seen fit. However, it is understood that until a reasonable effort has been made to collect the sums due from the insurance company or companies contractually obligated, "HCC" will refrain from collecting the amounts owed, directly from me. I understand that whatever amounts "HCC" does not collect from insurance proceeds, whether it is all or part of what is due; I personally owe and agree to pay to "HCC".
5. In addition to the above, I hereby waive the statue of limitations on collection and recover in this State of Delaware.
6. I further agree that this Authorization and Assignment is irrevocable and ongoing until all monies owed are paid in full.
7. This Authorization and Assignment will be in continual effect until revoked in writing by both parties.
8. I permit a copy of this Authorization and Assignment to be used in place of the original.

Date	Signature of Patient or Guardian	Printed Name of Patient or Guardian