

DR. DON LOUNSBURY

2600B LEBANON PIKE
NASHVILLE, TN 37214
(615)883-9000

AUTHORIZATION, ASSIGNMENT, CONSENT TO TREAT AND POWER OF ATTORNEY

In consideration of your undertaking to treat me, I agree to the following:

Medical Release

You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me.

Assignments of Benefits

I authorize the direct payment to you of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.

In the event any insurance company obligated by contractual agreement to make payment to me or the you for the charges made for your services refuses to make such payment upon demand by you, I hereby assign any such company (the pertinent data below) and authorize you to prosecute said action either in my name or your name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit. However, it is understood that until all reasonable efforts have been made to collect the sums due from the insurance company (or companies) contractually obligated, you will refrain from attempts and efforts to collect amounts owed directly from me. I understand that whatever amounts you do not collect from insurance proceeds (whether it be all or part of what is due) I personally owe you.

Power of Attorney

I, the undersigned, do hereby appoint this United Chiropractic Clinic and any of it's duly authorized agents to serve as lawful attorney invested with all powers and authority necessary to endorse and cash any checks, drafts or money orders which are made payable to the undersigned above or as co payee with this United Chiropractic Clinic when said payments are due for services rendered on behalf of the undersigned by the clinic.

Authorization to Treat

I, the undersigned, hereby authorize this United Chiropractic Clinic, (and whomever may be designated as assistants) to administer such examinations and treatment as they deem necessary.

If placed out for collection or suit is brought on this account, I agree to pay reasonable attorney fees and collection costs.

DATE

PATIENT'S SIGNATURE

WITNESS