AUTHORIZATION, LEIN, ASSIGNMENT OF BENEFITS & CONSENT/GUARANTEE OF PAYMENT

DIRECTION TO PAY: TO:_____/_____

I hereby authorize you, my insurance company and/or my attorney, to pay directly to, such sums as may be due and owing OptiLife Chiropractic LLC for services rendered to me, both by reason of accident or illness, and by reason of any other billed services that are due to OptiLife Chiropractic LLC, and to withhold such sums for any disability benefits, medical payments. No Fault benefits, or any other insurance benefits obligated to be reimbursed to me or from any settlement, judgment, or verdict, on my behalf as may be necessary to adequately protect said .OptiLife Chiropractic. I hereby further give a lien to said Assignees against any and all insurance benefits named herein and any and all proceeds for which I have been treated by OptiLife Chiropractic LLC. This document is to act as an assignment of my rights and benefits to extent of the Assignees' services provided and is in accordance with Florida Statues 627.736.

ASSIGNMENT OF CAUSE OF ACTION: In the event my insurance company fails to make payments for me for charges made by OptiLife Chiropractic LLC for services, upon demand by me or OptiLife Chiropractic LLC, I hereby assign and transfer OptiLife Chiropractic LLC, any and all cause of action that I might have or that exist in my favor against such company and authorize OptiLife Chiropractic LLC, to prosecute said cause of action either on my name or in the Assignees' name, and further I authorize OptiLife Chiropractic LLC to compromise, settle or otherwise resolve said claim or cause of action as they see fit. It is also understood that the Assignee shall be entitled to reasonable attorney's fee and cost of colection if they prevail under PIP statute. To avoid exhaustion of No Fault benefits while OptiLife Chiropractic LLC, pursues it's right under this assignment, I direct my insurance company to set aside and place in escrow any disputed amounts or reductions until the resolution of such dispute.

CONSENT FOR TREATMENT & GUARANTEE OF PAYMENT: I hereby consent to the rendering of health care services for me or my child listed below. I voluntarily consent to examination and x-rays to aid in evaluating me/our case.

I declare that I am not pregnant, nor is pregnancy suspected. I also voluntarily authorize the doctor to treat my condition as she deems appropriate. I have been advised that OptiLife Chiropractic LLC is willing to wait for payment for these services, provided that there continues to be a reasonable chance that payment will be made either by insurance proceeds or out of the settlement of a liability claim. I authorize my attorney to guarantee payment out of any settlement that is awarded in regard to my case and that I authorize this payment to be made before any monies are released to me.

I understand that if it is determined either:

A. That there is no insurance company obligated to pay for the services, or if the insurance company involved refuses to acknowledge an assignment to the assignee or make other provisions for the protection of the interest of OptiLife Chiropractic LLC, or

B. If a liability claim exists, and my attorney refuses to agree to protect the interest of OptiLife Chiropractic LLC, under and LOP (letter of protection) or if I have not engaged the services of an attorney:

I understand that I remain personally responsible or any deductibles or co-payments associated with my insurance coverage. Furthermore, I understand that if this Assignment, Lien and Authorization are deemed invalid by a court of competent jurisdiction, then I remain personally responsible for the total amounts due to OptiLife Chiropractic LLC for their services. I further understand and agree that this Assignment, Lien Authorization does not constitute any consideration for OptiLife Chiropractic LLC to await payments of any deductibles or co-payments and they may demand these payments from me immediately upon rendering services at their option. It is also agreed that this Assignment, Lien, Authorization be deemed invalid, then OptiLife Chiropractic LLC may immediately demand payment from me for the full amount due to OptiLife Chiropractic LLC. If payment is required of me for services rendered by OptiLife Chiropractic LLC, I agree to make payments on monthly bases until my bill is paid in full or my liability is settled, whichever occurs first. (Unless a separate written arrangement is made with OptiLife Chiropractic LLC) When no LOP exists and the account reaches 60 days overdue, it may be subject to 1.5% per month (18% per year) finance charge. If the default amount is referred to a collection agency and/or for legal action, I agree to pay for reasonable costs of collection.

RELEASE OF INFORMATION: I authorize OptiLife Chiropractic LLC to release any information pertinent to my case to any insurance company, adjuster, or attorney to facilitate collection under the Assignment, Lien and Authorization. I agree that the above mentioned Assignees be given Special Power of Attorney to endorse/sign my name on any and all checks And claim forms for payment of my bills. I agree under the terms of HIPPA that OptiLife Chiropractic LLC may use my personal health information as needed to collect on said debts. I also authorize any holder of medical/chiropractic information about me to release the health care financing administrators or insurance adjustor agents any information needed to determine these benefits for related services.

My signature below verifies I have read and understand the above condition of acceptance as a patient and or guardian at OptiLife Chiropractic LLC and I agree to these conditions.

Print Patient Name | Signature of Patient or Guardian | Date