Assignment Of Payment

My attorney and/or insurance carrier are hereby requested and authorized to pay directly to West Functional Chiropractic monies due on account, the same to be deducted from any settlement made on my behalf. Further, I agree to pay West Functional Chiropractic the difference, if any, between the total amount of charges on my account and the amount paid by the attorney and/or insurance carrier. It is further understood that I, the undersigned, agree to pay West Functional Chiropractic the full amount of charges on my account should my condition be such that it is not covered by my policy or if for any reason the insurance carrier refuses to pay my claim.

Patient's Signature:_____________________________________ Date:__________________

Printed Name:____

Witness:____

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