WELLCARE
CHIROPRACTIC CENTER

230 Lowell Street, Wilmington, MA 01887

(978) 658-7700 • (978) 658-7703 fax

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

Authorization to Release Information
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 as a result of professional services rendered by you, and I hereby release you of any consequence thereof.

Authorization to Pay Directly to Doctor
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/or by any insurance company obligated to reimburse me for the charges for your services or otherwise obligated to reimburse me for the charges for your services or otherwise obligated to make payment to me or you based in whole or in part upon the charges made for your services.

Assignment of Cause of Action
In the event any insurance company is obligated by contractual agreement to make payment to me or to you for the demand by you. I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is/are believed to be correctly set forth under 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 the amounts owed directly from me. I understand that whatever amounts you do not collect from the insurance proceeds (whether it be all or part of what is due). I personally owe you, and agree to pay in a current manner.

Acknowledgement and Understanding
I hereby acknowledge that I am receiving (or about to receive) health care services at the Wellcare Chiropratic Center, Inc. and that I have been advised that the doctor(s) providing the services is/are 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 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 doctor(s) or make other provisions for the protection of the doctor(s); or

b) If a liability claim exists, and my attorney refuses to agree to protect the interest of the doctor(s), or if I have not engaged the services of an attorney;

Then payment for services rendered by the doctor(s) at Wellcare Chiropractic Center, Inc. will be made on a current basis and my bill paid in full as soon as my liability claim is settled or the passage of three months from my last visit, whichever occurs first.

Member Name (please print)	Member (Guardian) Signature	Date

Guardian Name (please print)	Relationship to Member