DR. JUAN ESCOBAR, D.C.
Doctor of Chiropractic Medicine
(Activator Methods Technique)
State and National Board Certified

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AUTHORIZATION AND ASSIGNMENT OF BENEFITS

For good and valuable consideration, I, the undersigned patient, execute this document hereby assigning to Escobar Chiropractic LLC. (hereafter known as Provider) the right to receive insurance benefits directly from any insurance company that may be obligated to provide insurance benefits, to me or on my behalf, for services rendered by Provider, for a motor vehicle accident that occurred on or about _____.

Any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, for the aforesaid accident for services provided to me by Provider, is hereby directed to issue payment for those benefits directly to and payable to Provider.

I authorize Provider to release any information deemed appropriate concerning my health condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges to Provider by me.

I authorize and assign the direct payment to Provider any sum I now or hereafter owe Provider by my attorney out of the proceeds of any settlement of my case.

I give assignment and lien against any claims against a third party whose negligence may have caused my injury, up to the amount of the bill for treatment, to Provider.

In the event any insurance company obligated by contractual agreement to make payment to me, or on my behalf, for charges made for services provided to me by Provider, refuses to make such payment upon demand by Provider, I also authorize, assign, and transfer to Provider the right to file suit and pursue all legal remedies to obtain payment for services rendered. This authorization to file suit is an assignment of my cause of action to obtain payment for services provided to me by Provider and includes the assignment to pursue declaratory relief or any other legal remedies.

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.

Provider accepts the aforesaid assignment and hereby notifies any insurer issuing payment that Provider objects to any “repricing” or reduction of billed amounts unilaterally made by any insurer. Any such reduced payments issued by any insurer are accepted under protest and without waiving any right of Provider to pursue all legal remedies against the insurer.

I waiver the Statue of Limitations regarding Provider’s right to recover.

ADDITIONAL AUTHORIZATIONS AND DIRECTIONS TO INSURER

AUTHORIZATION FOR DISCLOSURE OF INSURANCE DECLARATIONS PAGE: I, the undersigned patient and insured, further authorize, and direct any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, to provide to Dr. Juan Escobar, D. C. (hereafter known as Provider) a copy of any declarations page of any insurance policy that may provide any insurance benefits to me for aforesaid accident.

AUTHORIZATION FOR DISCLOSURE OF INSURANCE PAYMENT RECORD: I further authorize and direct any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, to provide to Provider a copy of any ledger or payment record of payments made under any insurance coverage available to me, without redacting the names of any other medical provider or entity to whom insurance benefits have been paid and without redacting the amount of any insurance benefits that have been paid.

DIRECTION NOT TO EXHAUST BENEFITS BY PAYMENT OF OTHER CLAIMS: I further authorize and direct any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, to not exhaust insurance benefits or coverage until all claims submitted by Provider have been paid in full, or at 80% of the amount billed if my coverage is limited to 80% for medical claims. I direct the aforesaid insurance company to hold in escrow the amount in dispute, and if other claims would exhaust benefits, I direct the aforesaid insurance company to hold in escrow the disputed amount and to not exhaust benefits or coverage by payment of the amount I have hereby requested be held in escrow. I further authorize and direct the aforesaid insurance company to notify Provider that benefits have been exhausted except for the amount held in escrow, to enable Provider to attempt to resolve the disputed claim in a manner acceptable to Provider.

DIRECTION TO INSURER TO MAINTAIN CONFIDENTIALITY: I further direct any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, to maintain the privacy and confidentiality of my medical records. I do not authorize any insurer to provide my medical records to anyone without first obtaining a written authorization from me to provide the medical records to any other entity.

AUTHORIZTION FOR RELESE OF RECORDS TO PROVIDER: I hereby authorize any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, to release a copy of my complete medical records in possession of such insurer to Provider upon the request of Provider. This authorization includes the authorization to release to Provider a copy of any medical examination or evaluation of me requested by any insurance company.

DIRECTION TO INSURER TO PROVIDE TO PROVIDER ADVANCE NOTICE OF IME OR EUO: I further authorize and direct any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, to provide at least 15 days advance notice to Provider of any physical examination or examination under oath of myself that any insurance company may schedule.

Please read this document completely before signing. If you do not completely understand or have any questions about this document, please ask us to explain it to you. Your signature below is your agreement that you fully understand, and you fully agree to the terms of this document.

_____ Date_____

Patient (or legal guardian) Signature

_____ Date_____

Authorized signatory for Dr. Juan Escobar, D.C.