Registration Information

Name: _____
First Middle Initial Last

Address: _____

_____
City State Zip

Email Address:

Phone Number:

SSN#: - - Date of birth: ____/____/____ Gender: ❑ M ❑ F

Are you? ❑ Single ❑ Married ❑ Divorced ❑ Other Spouse's Name:

Employer: _____ Occupation: _____

Address: _____

_____
City *State* *Zip*

Work Phone: ( ) - Fax: ( ) - E-Mail Address:

Insured Information (if other than patient)

Name:
First *Middle Initial* *Last*

Address:

City *State* *Zip*

Home Phone: ( ) - Fax: ( ) - E-mail Address:

SSN#: - - Date of Birth: ____/____/____ Gender: ❑ M ❑ F

How did you find us?				
	❑ Patient?	If yes, who?	❑ Yellow Pages?	
	❑ Other Doctor?	If yes, who?	❑ Sign?	
	❑ Other?	Explain:	❑ Mailing?	

1. What date did your symptoms begin? _____/_____/_____
2. Have you had these symptoms before? _____ If yes, when? _____
3. How did this happen?

4. Is this injury work or auto accident related? ❑ No ❑ Yes

5. Are your arms or legs involved? ❑ No ❑ Yes

6. Please state your chief complaint _____

7. What makes it better or worse? _____

8. Please list all medications prescribed to you within the last year _____

_____

9. What kind of activities do you participate in during your free time? _____

Have you ever had or are you having problems with any of the following?

❑ No	❑ Yes	Headaches	If yes, how often and when?	_____
❑ No	❑ Yes	Dizziness	If yes, how often and when?	_____
❑ No	❑ Yes	Sinus pain	If yes, how often and when?	_____
❑ No	❑ Yes	Neck pain	If yes, how often and when?	_____
❑ No	❑ Yes	Upper back pain	If yes, how often and when?	_____
❑ No	❑ Yes	Mid-back pain	If yes, how often and when?	_____
❑ No	❑ Yes	Low back pain	If yes, how often and when?	_____
❑ No	❑ Yes	Shoulder pain	If yes, how often and when?	_____
❑ No	❑ Yes	Chest pain	If yes, how often and when?	_____
❑ No	❑ Yes	Heart	If yes, how often and when?	_____
❑ No	❑ Yes	Stomach	If yes, how often and when?	_____
❑ No	❑ Yes	Bladder	If yes, how often and when?	_____
❑ No	❑ Yes	Liver	If yes, how often and when?	_____
❑ No	❑ Yes	Kidney	If yes, how often and when?	_____
❑ No	❑ Yes	Colon	If yes, how often and when?	_____
❑ No	❑ Yes	Hip	If yes, how often and when?	_____
❑ No	❑ Yes	Circulation	If yes, how often and when?	_____
❑ No	❑ Yes	Prostate	If yes, how often and when?	_____
❑ No	❑ Yes	Breast	If yes, how often and when?	_____
❑ No	❑ Yes	1. Have you ever been in an accident?		
❑ No	❑ Yes	2. Have you ever been hospitalized or had any surgery?		
❑ No	❑ Yes	3. Have you ever had measles, mumps, rheumatic fever, sexually transmitted disease or any other type of infection?		
❑ No	❑ Yes	4. Have you or your family ever had cancer?		
❑ No	❑ Yes	5. Have you or a family member ever been diagnosed with diabetes?		
❑ No	❑ Yes	6. Has any family member ever had neck, back, or spinal problems?		
❑ No	❑ Yes	7. Do you drink alcohol, smoke cigarettes, or ever use any recreational drugs?		
❑ No	❑ Yes	8. If female, any possibility of currently being pregnant?		

If you answered "yes" to any of the items above, please explain: _____

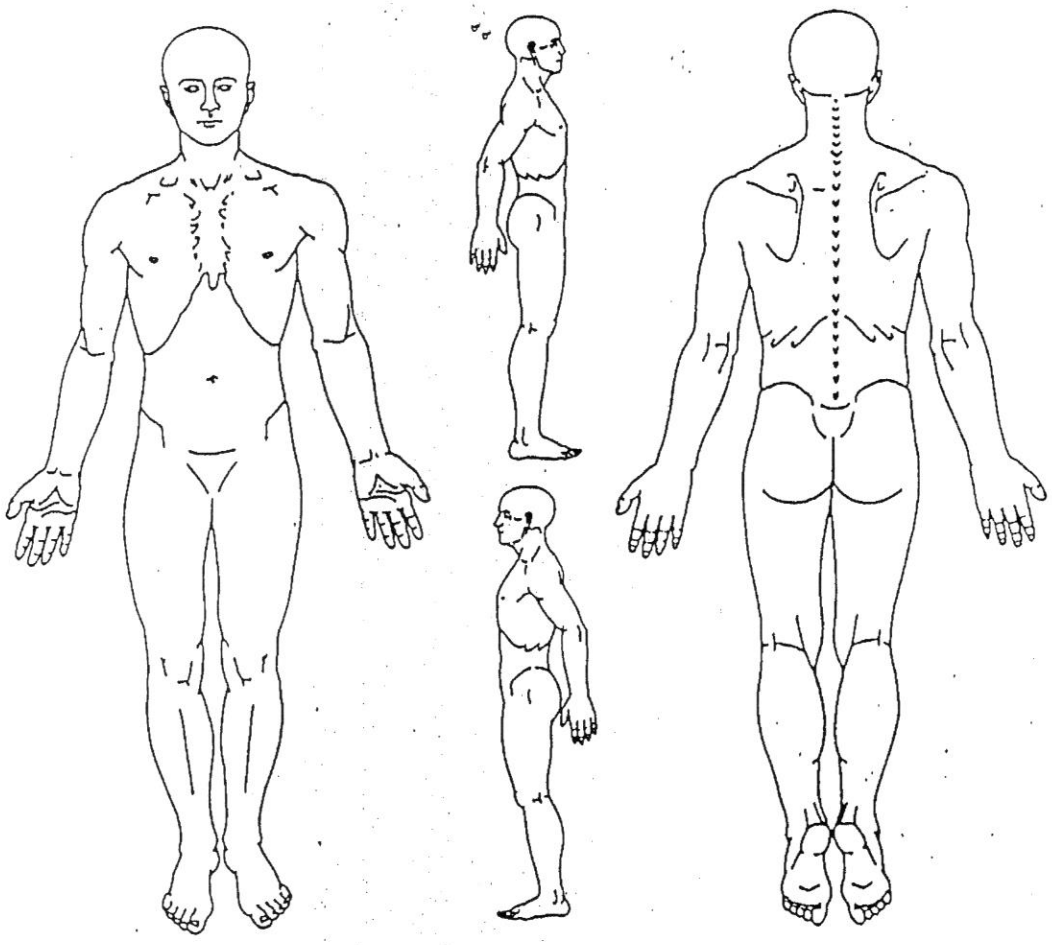
Patient Signature_____ Date_____

Parent or Guardian_____ Date _____

Please use the appropriate letters below to indicate the type and location of your sensations right now.

A=ACHE B=BURNING S=STABBING

N=NUMBNESS P=PINS & NEEDLES O=OTHER



Please rate the severity of your pain by circling the appropriate number on each line below.

RIGHT NOW	No pain |0	1	2	3	4	5	6	7	8	9	10| Unbearable Pain
LEAST in the past week	No pain |0	1	2	3	4	5	6	7	8	9	10| Unbearable Pain
WORST in past week	No pain |0	1	2	3	4	5	6	7	8	9	10| Unbearable Pain
AVERAGE in past week	No pain |0	1	2	3	4	5	6	7	8	9	10| Unbearable Pain

Patient Signature _____ Printed Name _____ Date _____

Parent or Guardian Signature _____ Printed Name _____ Date _____

OFFICE POLICY FOR FINANCES AND INSURANCE

1. We will need to verify coverage on all patients prior to beginning treatment or the patient will be financially responsible for all costs until such verification of coverage occurs. We will provide you with a copy of your verification of coverage from your third-party payor. We ask that you call your insurance provider to verify its accuracy.

2. Should your insurance provider quote your coverage differently than what was provided to us, as noted on the verification of coverage, please notify us as soon as possible.

3. You will receive copies of EOB's (explanation of benefits/payments to your Chiropractor) from your insurance company. They will come in the mail. Please open each one and compare what the EOB states as your financial responsibility vs. the amount you pay each visit in our offices. Any differences between the two should be brought to our attention immediately. If additional amounts are due, please be prepared to pay that amount at your next visit. After reviewing the EOB, please place it into the manila folder that was given to you on your first visit, so that you will have all your Chiropractic records in one place.

4. We will file all claims as a courtesy and/or requirement for third party reimbursement, however, you may still be held responsible for payment should such claim be denied.

5. We allow up to 60 days before claims will be the responsibility of the patient to pay. Interest on the claims will not occur until 30 days past the patient's responsibility date or thirty days after denial of third-party payment, whichever occurs first.

6. Statements will only be sent if there is a balance due by the patient.

7. Responsibility for obtaining and maintaining referrals for HMO plans is that of the patient. We cannot alter or modify dates of service (or anything else) to accommodate improper filing procedures. If coverage is verified after a treatment date in which the patient paid in full, we will file that claim as a courtesy and the patient will be eligible for a refund after we receive payment for such date.

8. Our office will need to be notified immediately if there is any change in the following: health insurance, patient address, patient home telephone number, coverage termination or cancellation or any other reason that may affect third party reimbursement.

9. Non-compliance for payment due may result in a $25.00 late payment/no payment and/or interest charges.

10. Deductibles and all co-payments are expected at the time of service and may be paid ahead.

11. Unless other arrangements have been made, if a patient's treatment plan is greater than once every 3 weeks, the patient will no longer be eligible for health insurance assignment. Most health insurance considers this to be maintenance care and does not reimburse for this. You may still be eligible for insurance reimbursement; however, we will ask that the patient pay us and then the patient can submit the bill to their insurance carrier for direct reimbursement.

12. This office does not promise that an insurance company will pay for usual and customary charges of this office, nor will this office enter into any dispute with an insurance company over reimbursement or the amount of reimbursement.

13. I understand, should additional information be asked from Colonial Heights Chiropractic and Wellness Center (i.e. notes), that I would allow 15 working days for such requested information.

14. I have read over and agree to the financial considerations for treatment costs.

Patient Signature : _____ Date : _____

Parent or Guardian : _____ Date : _____

FINANCIAL CONSIDERATIONS

1. Your first visit to our office will consist of an orthopedic-neurological examination and x-rays, if medically necessary. You may, also, receive palliative therapy. Therapies for most conditions include interferential stimulation, ice/heat and/or therapeutic activities.
2. On your second visit the doctor will provide you with a report of findings and recommendations for care. After meeting with the doctor, our receptionist will review the financial obligations of your care. Chiropractic adjustments will only be performed after notification and mutual agreement of financial costs, treatment plan and terms of care.
3. A schedule of costs for procedures is provided for you below:

Examination:	New Patient Brief Exam	= $108.00
	New Patient Expanded Exam	= $186.00
Re-examination:	Established Patient Brief Exam	= $54.00
	Established Patient Extended Exam	= $114.00
Office Visit/Adjustment:	Adjustment (1 to 2 regions)	= $66.00
	Adjustment (3 to 4 regions)	= $72.00
	Adjustment (5 or more regions)	= $78.00
	Adjustment (extremities)	= $42.00
X-rays: Technical Component (Per film)	Cervical x-ray	= $27.00
	Thoracic x-ray	= $34.00
	Lumbo-Pelvic x-ray	= $34.00
	Extremity/Individual Bone (2-3 views)	= $27.00 to $34.00
X-Rays: Professional Component (Per film)	Cervical (series)	= $53.00
	Thoracic (series)	= $68.00
	Lumbar (series)	= $68.00
Therapy:	Interferential Stimulation	= $30.00
	Moist Heat/Ice	= $15.00
	Therapeutic Activities	= $36.00
	Therapeutic Exercises/Stretching	= $36.00

May include one or more of the following:

- Manual lumbar or mechanical cervical traction
- Soft tissue/muscle release
- Strength Development
- Vibrating fascia release
- Others

Costs for care:	Average visit during intensive care and phase 1-	$180.00
	Average visit during phase 2 and supportive care -	$150.00
Durable Goods:	Must be paid upon receipt. Remember these goods may not be returned for refund or credit.	

I have read and understand the cost of services provided. These prices are subject to change without notice.

Patient Signature_____Date_____

Parent or Guardian_____ Date_____

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and / or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Colonial Heights Chiropractic and Wellness Center all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect for seven years or until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

I have read your authorization and legal assignment of benefits and agree to its terms. My signature authorizes you to disclose my PHI in the manner described above and acknowledges that I will receive a copy of this completed form for my own records.

Print Patient Name	Signature	Date
Print Parent or Guardian Name	Signature	Date

CONSENT TO TREATMENT

I hereby certify all information provided on the patient registration information form is complete, truthful and to the best of my knowledge. I have received and read the notice of privacy practices for Colonial Heights Chiropractic and Wellness Center. I authorize Colonial Heights Chiropractic and Wellness Center to perform Chiropractic manipulations, therapeutic modalities, x-ray examinations, consulting services, diagnostic procedures, and any other procedure necessary for treatment. I understand that any outstanding account balance will be subject to 18% annual interest rate. I also understand that any late payments will be subject of a $25 service charge per billing cycle. In addition, I understand that any outstanding balance owed to Colonial Heights Chiropractic and Wellness Center that becomes delinquent will result in legal action to collect the outstanding balance and that I will incur filing fees, attorney fees or whatever fees may occur as a result of my delinquent account. I understand these fees will total no less than 33 1/3% of monies owed. I also understand that if an appointment is cancelled or missed without 24-hour notification, that I will incur a $50 fee, as another patient may have needed the time that I was scheduled. I have also chosen to receive chiropractic care for my specific condition understanding my other options for treatment as well as the risks involved. Furthermore, any returned checks will automatically incur a $35 service charge. If I am not of legal age my parent or guardian will in turn guarantee my obligations to Colonial Heights Chiropractic and Wellness Center, and that the patient or guardian consents to treatment performed by Colonial Heights Chiropractic and Wellness Center, for the minor (patient).

Print Patient Name	Signature	Date
Print Parent or Guardian Name	Signature	Date

Chiropractic Centers of Virginia

Personal Injury-Patient Data Form

Name:_____ Date:_____ File #:_____

History of occurrence:

Date of accident:_____ Time:_____(AM / PM)
Driver of car:_____ Where were you seated:_____
Owner of car:_____ Year and model of car:_____
What was the approximate damage done to your car? $_____
Visibility at time of accident: poor / fair / good : _____
Road conditions at time of accident: icy / rainy and wet / clear / dark :_____
Where was your car struck? Right / left / rear / front / side : _____
Type of accident: ( ) Head on collision ( ) Broad side collision
( ) Rear end collision ( ) Front impact
( ) Non-collision:_____

Impact/Seat Belt/Headrest/Speed

Describe in your own words what happened to you upon impact:_____
_____
Did you see the accident coming? Yes / No
Did you brace for impact? Yes / No
Were seat belts worn? Yes / No
Were shoulder harnesses worn? Yes / No
Does your car have headrests? Yes / No
If yes, what was the position of those headrests compared to your head before the accident?
( ) Top of headrest even with bottom of head
( ) Top of headrest even with top of head
( ) Top of headrest even with middle of neck
Was your car braking? Yes / No
Was your car moving at the time of the accident? Yes / No
If yes, how fast would you estimate you were going? _____m.p.h.(estimate)
How fast was the other car traveling? _____m.p.h. (estimate)

Head/Body Position/Able to move body

Head/Body position at time of impact:
( ) head turned right/left ( ) body straight in sitting position
( ) head looking back ( ) body rotated right/left
( ) head straight forward
At the time of accident, recall what parts of your head or body hit what parts on the inside of your car: _____
As a result of the accident you were:
( ) Rendered unconscious ( ) Dazed, circumstances vague ( ) Shaken up but could function
Could you move all parts of your body? Yes / No
If no, what parts and why? _____
Were you able to get out of the car and walk unaided? Yes / No
If no, why not? _____

Symptoms from accident

Did you get bleeding cuts or bruises? Yes / No
If yes, what bleeding cuts did you get from this accident? _____
If yes, what bruises did you get from this accident? _____

Please describe how you felt immediately after the accident. Please be specific.

Later that day:_____Night: _____
The next ____ day(s):_____
Check the symptoms apparent since the accident:

( ) Headache	( ) Loss of smell	( ) Numbness in fingers
( ) Neck pain/stiffness	( ) Loss of taste	( ) Cold hands
( ) Mid back pain	( ) Loss of memory	( ) Cold feet
( ) Low back pain	( ) Fatigue	( ) Diarrhea
( ) Eyes sensitive to light	( ) Tension	( ) Constipation
( ) Pain behind eyes	( ) Shortness of breath	( ) Chest Pain
( ) Dizziness	( ) Irritability	( ) Nervousness
( ) Fainting	( ) Depression	( ) Cold sweats
( ) Ringing/buzzing ears	( ) Sleeping problems	( ) Anxious
( ) Loss of balance	( ) Numbness in toes	( ) Other_____

Work Status History
Occupation: _____ Employer: _____
Have you missed time from work? Yes / No
If yes,
Full time off work _____ to _____: _____to _____
Part time off work _____to _____: _____to _____
_____ Been unable to work since accident.

First Doctor/Hospital/Clinic Seen
Did you go to seek medical help immediately/ soon after the accident? Yes / No
If yes, how did you get there? _____Someone drove me _____Ambulance
_____Drove own car _____Police
Doctor 1/Hospital/Clinic seen: _____ Date of first visit: _____
Were you examined? Yes / No Were X-rays taken? Yes / No
Were you given treatment? Yes / No
If yes, what treatment was given to you? _____
What benefits did you receive from the treatment? _____
Date of last treatment: _____
Doctor 2/Clinic seen:_____ Date of first visit: _____
Were you examined? Yes / No Were X-rays taken? Yes / No
Were you given treatment? Yes / No
If yes, what treatment was given to you? _____
What benefits did you receive from the treatment? _____
Date of last treatment: _____
Doctor 3/ Clinic seen:_____ Date of first visit: _____
Were you examined? Yes / No Were X-rays taken? Yes / No
Were you given treatment? Yes / No
If yes, what treatment was given to you? _____
What benefits did you receive from the treatment? _____
Date of last treatment: _____

Prior Similar Symptoms
Did you have any physical complaints JUST BEFORE THE ACCIDENT? Yes / No
If yes, please describe in detail: _____
PRIOR to this accident, have you EVER had symptoms similar to what you're experiencing now? Yes / No
If yes, please explain: (briefly include past falls, injuries, accidents, operations, etc.)

Patient or Guardian Signature: _____ Date: _____

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Colonial Heights • 209 Temple Ave • Colonial Heights, VA 23834 • (804)-523-8023

IRREVOCABLE ASSIGNMENT OF BENEFITS, AUTHORIZATION AND LIEN

To Whom It May Concern:

This Irrevocable Assignment of Benefits, Authorization and Lien (this "Assignment") is made by and between _____ ("Patient") and __CCVA__("Health Care Provider"). With this Assignment, and in consideration of treatment without having to render concurrent payment, Patient, hereby irrevocably transfers sets over and assigns to Health Care Provider all insurance and/or litigation proceeds to which Patient is now or may hereafter become entitled, including those listed below, up to the total amount due and owing the Health Care Provider for services rendered to the Patient by reason of accident or illness, including interest thereon, as well as any other charges that are due or may become due the Health Care Provider, including, without limitation, requested reports, collection costs and expenses and attorney's fees, and Patient further hereby irrevocably authorizes and directs any insurance company and/or attorney to whom an original or copy of this Assignment is provided to withhold from Patient and pay directly to such Health Care Provider such amount(s) from (1) any insurance benefits payable to Patient or on Patient's behalf, including, but not limited to, medical payments benefits, No Fault benefits, health and accident benefits, foundation grants, governmental or agency benefits, worker's compensation benefits or any other insurance proceeds or benefits of any kind which are payable to or on behalf of the Patient, and (2) any litigation proceeds (which may include insurance proceeds) from any settlement, judgment or verdict in Patient's favor as may be necessary to fully pay any and all financial obligations owed to the Health Care Provider by the Patient. This Assignment is to be complete and current transfer of Patient's right, title, and interest, separate from any statutory or contractual lien or claim to which the Health Care Provider may also be entitled. Patient acknowledges that Health Care Provider has a substantial pecuniary interest in the enforcement of this Assignment.

The Patient further agrees that, in the event the insurance company and/or attorney obligated hereunder to make payments to the Health Care Provider fails or refuses to make payment for the full amount due as set forth above, this Assignment is a full, immediate and complete assignment of all the Patient's rights, title, interest, remedies and benefits in and to the assigned property to the extent of the Health Care Provider's total claim amount; therefore, Patient hereby irrevocably and fully assigns and transfers to the Health Care Provider any and all causes of action that Patient might have or that might exist in Patient's favor against such insurance company and/or attorney with respect to the assigned property. In addition to the foregoing assignment, Patient hereby authorizes, nominates and appoints as Patient's attorney-in-fact any officer of Health Care Provider, to prosecute said causes(s) of action either in Patient's name or in the Health Care Provider's name and Patient further authorizes the Health Care Provider to compromise, settle or otherwise resolve said claim(s) or cause(s) of action as it sees fit.

In further consideration of the services provided by the Health Care Provider, Patient hereby grants a lien to said Health Care Provider against any and all insurance benefits and litigation proceeds outlined in the first paragraph above which may be payable to or on behalf of the Patient as a result of the injuries or illness for which Patient has been treated by said Health Care Provider. The Patient further agrees that the statute of limitations applicable to Health care Provider's right to demand payment from the patient shall be tolled for all reasonable times that negotiations or litigation between third parties and the Patient are ongoing.

Patient hereby acknowledges that Virginia law imposes a lien in the amount of $750.00 upon Patient's claim against the individual or entity whose negligence is alleged to have caused Patient's injuries.

Notwithstanding the foregoing, the Patient agrees that until the Health Care Provider is paid in full, the Patient shall remain personally and fully responsible for and promises to pay the total amount due the Health Care Provider (including principal, interest, collection costs and attorney's fees of 35%) until fully paid. The Patient further understands and agrees that this Assignment does not constitute any agreement of or consideration for the Health Care Provider to await payments from any source, and in the event the Health Care Provider deems itself in its sole discretion insecure as to the prospect payment, it may demand payments from Patient immediately upon rendering services at its option and proceed to collect same through legal means if necessary.

Patient authorizes the Health Care Provider to release this Assignment and any information pertinent to Patient's case to any insurance company, adjuster or attorney to facilitate collection under this Assignment. Patient hereby nominates and appoints any officer of the Health Care Provider as Patient's attorney-in-fact to endorse/sign Patient's name on any and all checks for payment of the services provided to Patient by said Health Care Provider.

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In the event that any part or provision of this Assignment shall be determined to be invalid or unenforceable, the remaining parts and provisions of this Assignment which can be separated from the invalid, unenforceable provision shall continue in full force and effect.

Notice regarding the assignment of medical expense benefits is provided in a separate document. I have been presented with and had an opportunity to read the notice. Acknowledged:_____(Patient's initials)

Witness the following signatures and seal as of the indicated date:

Patient

Patient's Signature_____

Printed Name_____

Date_____ SS#_____

Witness_____

Health Care Provider

By:
Its Owner

Date_____

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THIRD PARTY REIMBURSEMENT: INJURY CLAIM

1. We accept injury claims in this office under the following conditions:
(Place a checkmark in ONE box and initial after the applicable term for acceptance of case)

A. ☐ Accept. The patient has an attorney retained who will honor a settlement lien on any unpaid case balance. _____

B. ☐ Accept. Patient pays for each service and can be directly reimbursed from their health or auto insurance carrier or injury claim settlement. _____

C. ☐ Accept. Patient has a large enough med pay on their auto insurance to cover the proposed treatment plan and the patient agrees to sign a lien for direct reimbursement to our office. Any and all amounts not honored by your med pay would become the responsibility of the patient. ____

D. ☐ Accept. Patient has health insurance that would pay for treatment costs. The patient would have to agree to our office policy for health insurance acceptance. Any and all amounts not honored by your health insurance plan would become the responsibility of the patient. _____

2. Patient will be financially responsible for any charges for reports, photocopies, postage charges, narratives, or reports; the doctor based on the case will determine the type of report provided. The charges that follow are subject to change without notice:

Clinical Notes/ Misc. Documentation	$10.00 administrative cost plus 50 cents per copy.
Brief Report	$45.00
Narrative Report	$150.00

3. Should your doctor's time be required for consultations, court appearances, or deposition, our charge is $375.00 for the first hour and $275.00 for every hour there forth for non-patient hours, and $750 for the first hour and $650 for every hour thereafter during patient treatment hours. Partial hours are rounded up to the nearest half-hour. Time starts when leaving an office until returning to the office (travel time).

4. Statements will be sent out regularly. It is necessary to make at least a $10.00 payment per billing cycle to avoid an automatically assessed $25.00 service charge for late payment/no payment. Don't let your account go into default. Collection proceedings will occur on overdue accounts.

5. Outstanding balances after sixty days will accrue a 1.5% interest charge assessed monthly.

6. I understand I will not receive a receipt that includes CPT codes unless I pay for those services in full.

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7. I have chosen and agreed with the terms for acceptance necessary for financial consideration of my case.

8. I have read and agree to abide by the office policy for committed care.

9. I have read over and agreed to the third party charges of my treatment costs.

Patient Signature: _____ Date _____

Parent or Guardian: _____ Date _____

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ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR FOR PRITAVE, GROUP, ACCIDENT AND/OR SETTLEMENT BENEFITS

RE: Direct payment to Chirocenters Management Corporation

Patient:_____
Claim Number:_____
Social Security Number:_____

I hereby instruct and direct the payment of all professional or medical expense benefits allowable and otherwise payable to me under my current automobile insurance policy and/or any settlement proceeds as payable for professional services rendered:

Chirocenters Management Corporation
P.O. Box 2890
Chesterfield, VA 23832

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS AGREEMENT.

This payment will not exceed my indebtness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment and/or settlement.

I am authorizing this direct payment to CMC, as I am not paying for my services when they are rendered. I also authorize the release of any information pertinent to my case to any insurance company, adjustor, or attorney involved in this case.

Insured Name (Print) **Date** **CCVA Witness Name (Print)** **Date**

Insured Signature **CCVA Witness Signature**

Claims Adjustor or Attorney Name (Print) **Date**

Claims Adjustor or Attorney Signature

A photocopy or fax of this Assignment shall be considered as effective and valid as the original.