Allied Chiropractic

Dr. Edward Wilkinson, D.C.

3347 Duke Street

Alexandria, VA 22314

(703) 823-1414

ASSIGNMENT AND AUTHORIZATION OF INSURANCE BENEFITS

I hereby authorize and direct you my insurance company to pay directly to Dr. Edward Wilkinson, D.C., 3347 Duke Street, Alexandria, Virginia 22314, such sums as may be due and owing his office for services rendered me both by reason of accident or illness and by reason of any other bills that are due his office and to withhold such sums from any disability benefits, medical payments benefits, No Fault benefits, health and accident benefits, workman's compensation judgment or verdict on my behalf as may be necessary to adequately protect his office. I hereby further give a lien to said office against any and all insurance benefits named herein and any and all proceeds of any settlement, judgment or verdict with may be paid to me as a result of the injuries or illness for which I have been treated by his office. This is to act as an assignment of my rights and benefits to the extent of the offices services provided.

In the event my insurance company which is obligated to make payments for me upon the charges made by Dr. Edward Wilkinson , D.C. office for their services refuses to make such payments upon demand by me or his office, I hereby assign and transfer to his office any and all causes of action that I might have or that might exist in my favor against such insurance company and authorize his office to prosecute said cause of action either in my name or in the office's name and further I authorize his office to compromise, settle or otherwise resolve said claim or cause of action as they see fit.

I understand that I remain personally responsible for the total amounts due the office for their services. I further understand and agree that this assignment and authorization does not constitute any consideration for the office to await payment and they may demand payments from me immediately upon rendering services at their option.

I authorize the office to release any information pertinent to my cause to any insurance company, adjuster or attorney to facilitate collection under this assignment and authorization. I agree that the above-mentioned office be given power of attorney to endorse/sign my name on any and all checks for payment of my doctor bill. In addition to the above, I hereby waive the statue of limitations regarding a physicians right to recovery.

Patient Signature: _____ Date: _____