Gray Clinic of Chiropractic

207 EAST OAK STREET
SUITE A
MAHOMET, IL 61853
TELEPHONE (217) 586-3886

Insurance Benefits Assignment & Medical Release

I hereby instruct my Insurance Company to make any & all payments directly to the GRAY CLINIC OF CHIROPRACTIC, Ltd. and mail payment directly to this Clinic at the above address. If my current policy prohibits direct payment to any Clinic, then I hereby also instruct my Insurance Company to make payment to me and mail said payment to me in care of this Clinic at the above address.

The health/medical expense benefits allowable and payable to me under my current policy, I hereby assign to the GRAY CLINIC OF CHIROPRACTIC, Ltd. as partial payment toward the total charge for professional services rendered to me or my dependent. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER MY INSURANCE POLICY. This payment will not exceed my indebtedness to this Clinic, and I agree to pay, in a current manner, any balance over and above this insurance benefit. I also authorize the release of any pertinent information to any insurance company or attorney involved in this case.

Patient/Parent Signature: Date:

Attorney / Doctor Lien, Letter of Protection, & Medical Release

I do hereby authorize the GRAY CLINIC OF CHIROPRACTIC, Ltd. to furnish my attorney/insurance company with any appropriate reports. I hereby authorize/direct my attorney to pay directly to this Clinic such sums as may be due and owing to this Clinic for services rendered to me both by reason of this most recent accident or any other outstanding bills I owe this Clinic. I do hereby authorize my attorney to withhold such moneys necessary to pay off my debt at this Clinic from any settlement, judgement, or verdict awarded me. I further give Lien on my case to this Clinic against any and all proceeds of my judgement, settlement, or verdict which may be paid to my attorney or myself as a result of the injuries for which I have been treated.

I agree not to rescind this document until the GRAY CLINIC OF CHIROPRACTIC, Ltd. is paid in full. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney shall honor this lien as inherent to the settlement. I agree to have my attorney make a timely settlement of this case. I fully understand that I am directly and fully responsible for all charges rendered to me or my dependent by this Clinic and that any charges not paid for by a settlement shall be my responsibility. I further understand that this Clinic is awaiting payment as a favor to me and that if timely progress is not made, full payment may be required before final settlement is achieved.

My signature verifies that I have read and understood this Lien and agree to all the conditions. I also agree that if my attorney will not sign and return this Lien to this Clinic for it's protection, full payment will be required IMMEDIATELY!

Patient/Parent Signature: Date:

The undersigned, being attorney of record for the above patient, do hereby agree to observe all the terms of this Lien and agree to withhold such sums from any settlement, judgement, or verdict, as necessary to adequately protect the GRAY CLINIC OF CHIROPRACTIC, Ltd. Please sign and return this copy. The original is on record at this Clinic.

Attorney's Signature: Date: