CATER CHIROPRACTIC CLINIC

I hereby authorize the release of all medical information necessary to process this claim, and information that is pertinent to my medical care. I assign all medical benefits including major medical benefits to which I am entitled, to CATER CHIROPRACTIC CLINIC.

I request that payment of authorized Medicare/Major Medical Insurance benefits be made to CATER CHIROPACTIC CLINIC for any services furnished to me. This assignment will be in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

I understand and agree that insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to the Doctor's office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, against the Doctor's recommendation, my account balance will be immediately due and payable.

Patient _____ Date _____
(Please Print)

Responsible Party _____

If an unforeseen overpayment occurs, whether by patient or insurance company, the credited amount will remain on the patients account and the patient will NOT be reimbursed (cash/check/credit) for that credit amount. However, the credit may be transferred between immediate family members only, for use within Cater Chiropractic Clinic PC.

I agree that in the event, my account is not paid in a timely fashion and my account is placed in collections, I will be responsible for any and all collection/attorney fees.

Signature _____ Date _____

Dr. Scott A. Cater 2004 E. Riverside Blvd. Loves Park, IL 61111 (779) 368-0584