

**Theriot Family Chiropractic Center
Assignment and Payment Agreement**

Patient Name: _____

DOB: _____

For Value Received, I hereby assign to:

Theriot Family Chiropractic Center, 612 Rue de Onetta, New Iberia, LA 70563 (hereinafter, referred to as Doctor) to the extent of my bill for health care services, any and all claims which I may have:

- (a) For benefits provided under any policy of insurance or other health care plan, including, but not limited to the following described policies:
- (b) Against any other party whose negligence may have caused my injuries or who may be legally responsible for my injuries, illnesses, or health care costs.

I further hereby assign to Dr. Tina Theriot a lien in the amount of my bill for health care service against the proceeds of any insurance policy, or health care plan, and against any claim which I may have against any other party whose negligence may have caused my injuries, or who may be legally responsible for my injuries, illnesses, or health care costs.

I here by direct payment to be made directly to Doctor. I hereby appoint Dr Tina Theriot as true and lawful attorney, irrevocable and with full power of substitution for me and in my name, to ask, demand, sue for, collect, endorse, sign and receive any such insurance or other benefits or claims against other parties for my injuries. Although, Dr. Tina Theriot shall be granted such powers contained herein. Dr. Tina Theriot is not obligated or compelled to exercise such powers, but may do so at Dr. Tina Theriot's discretion. I agree to cooperate with Dr. Tina Theriot in collecting any such amounts, including appearing in court, if necessary. Dr. Tina Theriot is further empowered to request and receive from any insurance company policies including a copy of such policy, and any information or supporting processing, or payment of any claim.

I understand this Assignment and the payment hereunder will be accepted by Dr. Tina Theriot as payment in full (with the exceptions of any deductible or coinsurance payments I am required to make by my insurance or health care plan contract) for bills submitted by Dr. Tina Theriot. All insurers and providers of health care benefits are hereby notified that this Agreement is subject to the financial arrangements with Dr. Tina Theriot as set forth below.

I realize that payment for services rendered by Dr. Tina Theriot is due upon receipt of the services, but that Dr. Tina Theriot has agreed to accept this Assignment as an accommodation to me and that Dr. Tina Theriot may revoke this Assignment at any time. I hereby waive any applicable statute of limitations in my favor, which may affect Dr. Tina Theriot's right to collect for her services.

In the event that I directly receive any check, draft, or other benefit subject to this assignment at a time when there is still a balance due for Dr. Tina Theriot's services I agree to deliver such check, draft, or benefits to Dr. Tina Theriot immediately upon my receipt, and the proceeds thereof shall be applied to my account balance.

In the event that any provision of this agreement is determined to be invalid or unenforceable, all other provisions of her agreement shall remain enforceable.

INSURANCE: office policy states that charges are due and payable at the time services is rendered. This applies to insurance coverage as well. I understand that there is no guarantee that my insurance companies or pre-paid health plan will cover or pay for all of my charges. Notwithstanding denial, reduction of benefits or failure to pay for any reason, I understand that I am responsible for all remaining charges.

BILLING & CREDIT: Any statement remaining unpaid without satisfactory arrangements may be turned over to The Credit Bureau of Lafayette for collection.

Office policy dictates that assigning of any account 90 days past due. Should your account be referred to any agency for collection, you will be responsible for all collection and attorney fees incurred.

If you have any questions regarding your bill, please fee free to call the office. We will honor all arrangements made regarding your financial obligations.

Thank you for choosing us for your chiropractic needs

IN WITNESS WHEREOF, this agreement has been entered the day and year set for the below.

Witness

Patient Signature

Date