SECURITY AGREEMENT & ASSIGNMENT OF AN INTEREST IN A PERSONAL INJURY CLAIM

TO: Attorney/Insurance Carrier Doctor

_________________________________ _________________________________

_________________________________ _________________________________

RE: Patient's records and Security Agreement & Assignment of an Interest in a Personal Injury Claim.

I do hereby authorize the above doctor to furnish you, my attorney/insurance carrier, with a full report of his case history, examination, diagnosis, treatment and prognosis of myself in regard to my accident/injury which occurred/began on ___________________.

I hereby give a lien to said doctor on any settlement and direct you, my attorney/insurance carrier, to pay directly to said doctor such sums as may be due and owing him for service rendered to me, and to withhold such sums from such settlement, claim, judgment, or verdict as may be necessary to protect said doctor adequately. Prior to dispersing any such fees, it is the responsibility of the payor to verify with this office all outstanding balances.

I fully understand that I am directly and fully responsible to said doctor for all chiropractic bills submitted by him for service rendered me, and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, claim, judgment or verdict by which I may eventually recover said fee. I also understand and agree that I am responsible for any reasonable collections fees required to secure the doctor's payment.

I further understand that there is likely to be an outstanding balance at the end of my treatments. This balance may be due to uncovered expenses such as orthopedic supplies and/or any medically necessary treatment beyond that authorized by my health insurance coverage. I agree to make any/all co-payments as per my health insurance contract.

Dated: __________________________ Patient's Signature: ____

The undersigned being attorney of record or authorized representative of insurance carrier for the above patient does hereby acknowledge receipt of the above lien, and does agree to honor the same to protect adequately said above named doctor.

Dated: __________________________ Authorized Signature: ______________________________________

ATTORNEY/INSURANCE CARRIER:

Please date, sign, and return to doctor's office at once. Keep a copy for your records.