Smith Family Chiropractic & Wellness, LLC
200 N. 2nd Street/P.O. Box 1001
Eunice, La 70535
(337) 457-1376: FAX (337) 457-1379

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Smith Family Chiropractic & Wellness, LLC will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Smith Family Chiropractic & Wellness, LLC will be credited to my account on receipt.

In the event that care being rendered is due to a personal injury or worker's compensation injury for which I have retained an attorney, a Doctor's Lien will be sent to my attorney for signature to protect the Doctor's Fees at time of settlement. Should my attorney refuse or fail to sign the Doctor's Lien within 10 days of initiating care, I am directly responsible for payment of any outstanding balance immediately.

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 id I suspend or terminate my care and treatment; any fees for professional services rendered to me will be immediately due and payable.

_____ _____
PATIENT'S SIGNATURE SOCIAL SECURITY NO.

_____ _____
DATE DRIVER'S LICENSE NO.

Guardian or Spouse's
Signature Authorizing Care_____ Date:_____

I authorized the release of any medical information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

I authorized payment of medical benefits to Smith Family Chiropractic& Wellness, LLC for service(s) described.

Signed in Eunice, Louisiana, this_____ day of _____, 20____.