VITALE CHIROPRACTIC

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MEDICAL REPORT AND DOCTOR'S LIEN

I DO HEREBY AUTHORIZE DR. JOHN A. VITALE TO FURNISH YOU, ***INSURANCE COMPANY***, WITH A FULL REPORT OF HIS EXAMINATION, DIAGNOSIS, TREATMENT, PROGNOSIS, ETC. OF MYSELF IN REGARD TO THE ACCIDENT IN WHICH I WAS INVOLVED.

I HEREBY AUTORIZE AND DIRECT YOU, ***INSURANCE COMPANY***, TO PAY DIRECTLY TO SAID DOCTOR SUCH SUMS AS MAY BE DUE AND OWING HIM FOR MEDICAL SERVICES RENDERED TO ME BY REASON OF THIS ACCIDENT THAT ARE DUE HIS OFFICE AND TO WITHHOLD SUCH SUMS FROM ANY SETTLEMENT DUE MYSELF AS A RESULT OF THE INJURIES FOR WHICH I HAVE BEEN TREATED OR INJURIES IN CONNECTION THEREWITH.

I FULLY UNDERSTAND THAT I AM DIRECTLY AND FULLY RESPONSIBLE TO SAID DOCTOR FOR ALL MEDICAL BILLS SUBMITTED BY HIM FOR SERVICES RENDERED TO ME AS WELL AS ANY COST INCURRED TO COLLECT PAYMENT, INCLUDING LEGAL FEES, 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 BY WHICH I MAY EVENTUALLY RECOVER SAID FEE.

PLEASE ACKNOWLEDGE THIS LETTER BY SIGNING BELOW AND RETURNING TO THE DOCTOR'S OFFICE. I HAVE BEEN ADVISED THAT IF MY ***INSURANCE COMPANY*** DOES NOT WISH TO COOPERATE IN PROTECTING THE DOCTOR'S INTEREST, THE DOCTOR WILL NOT AWAIT PAYMENT, BUT WILL REQUIRE ME TO MAKE PAYMENTS ON A CURRENT BASIS.

DATED_____ PATIENT SIGNATURE_____

PLEASE PRINT PATIENT NAME_____

THE UNDERSIGNED BEING ***INSURANCE COMPANY*** OF RECORD FOR THE ABOVE PATIENT DOES HEREBY AGREE TO OBSERVE ALL THE TERMS OF THE ABOVE, AND AGREES TO WITHHOLD SUCH SUMS FROM ANY SETTLEMENT AS MAY BE NECESSARY TO ADEQUATELY PROTECT SAID DOCTOR NAMED ABOVE.

DATED_____

AGENT'S OR ADJUSTER'S SIGNATURE_____

PRINT AGENT'S OR ADJUSTER'S NAME_____

DATE OF ACCIDENT_____ FIRST DATE OF TREATMENT_____

PLEASE SIGN AND RETURN TO VITALE CHIROPRACTIC.