Shakley Chiropractic

Bayshore Medical Group

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Ryan D. Shakley, D.C.

ASSIGNMENT OF PROCEEDS, CONTRACTUAL LIEN AND AUTHORIZATION

(“Agreement”)

I hereby direct any and all insurance carriers, attorneys and agencies, governmental departments, companies, individuals and/or other legal entitles (“payers”), which may elect or be obligated to pay benefits to me for any medical conditions, accidents, injuries or illnesses, past or future (“condition”), to pay directly to, and exclusively in the name of, Shakley Chiropractic and Wellness Center, such sums as may be owing to Shakley Chiropractic and Wellness Center, for charges incurred by me, including but not limited to, charges for treatment, narrative reports, depositions, testimony and any other charges incurred by me at the Office (“charges”). I further grant a contractual lien to Shakley Chiropractic and Wellness Center, with respect to my charges, applicable to all payers, however, I understand that nothing in this Agreement shall be construed as an election by Shakley Chiropractic and Wellness Center to claim protection under any statutory lien law. For the purposes of this Agreement, “benefits” shall include, but shall not be limited to, proceeds from any settlement, judgement, or verdict, as well as any proceeds relating to commercial health or group insurance, disability benefits, worker’s compensation benefits, medical payment benefits, personal injury protection, lost wages benefits, lost services benefits, no-fault coverage, uninsured and uninsured motorist coverage, third-party liability distributions, malpractice proceeds, attorney retainer agreements, and any other benefits or proceeds payable to me for the purposes stated herein, regardless of whether such proceeds are related to my charges or not.

I further agree that, in the event a payer refuses to pay Shakley Chiropractic and Wellness Center, I hereby assign, insofar as permitted by law, all of my rights, remedies, and benefits to Shakley Chiropractic and Wellness Center, to extent of my charges, as well as any and all causes of action that I might have against such payer, to prosecute such causes of action either in my name or in the Office’s name, and to settle or otherwise resolve such causes of action as the Office sees fit.

In the event that I retain one or more attorneys to represent me in this matter, I will direct each attorney to issue a letter of protection to this office regarding my charges. Upon insurance, I hereby agree that such letter(s) of protection cannot be revoked or modified without the expressed written consent of this office. I further direct each attorney to provide immediate notice of to the Office regarding any funds received by the attorney relating to my accident, to promptly pay such Office, and to provide a full accounting of such funds to the Office upon its request.

I hereby direct all payers’ to release to Shakley Chiropractic and Wellness Center, any information regarding any coverage or benefits which I may have including, but not limited to, the amount of the coverage, the amount paid thus far, and the amount of any outstanding claims. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employees health care plan any claim, chose in action, or other right I have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical service.

I authorize this Office to release any information regarding my treatment or pertinent to my case(s) to all payers as defined above to facilitate collection under the Agreement. I hereby direct this Office to file a copy of this Agreement, together with any applicable charges, with any or all payers, regardless of whether a claim has been established with said payers. I hereby authorize Shakley Chiropractic and Wellness Center to endorse/sign my name on any and all checks listing me as a payee which are presented to this Office for payment of an account relating to me, my spouse or any of my dependents. I further authorize Shakley Chiropractic and Wellness Center to apply any credit balances on charges incurred by me to any other outstanding charges still owed by me, my spouse or my dependents, regardless of whether these other charges are related to my condition.

I understand that I remain personally responsible for the total amounts due to Shakley Chiropractic and Wellness Center, for their services. This Agreement does not constitute any consideration for this Office to await payments and it may demand payments from me immediately upon rendering services at its option. If payment is not made as agreed upon, the account will be turned over for collection. The patient, and/or guarantor, shall be responsible for and agree to pay all reasonable costs of collection including, but not limited to, reasonable collection agency fees, attorney’s fees and court costs. If any suit must be filed to collect an unpaid balance on an account, the patient and/or guarantor, agrees that such suit may be brought in courts of Anne Arundel County, Maryland and waives any objection to jurisdiction or venue.

This Agreement shall not be modified or revoked without the mutual written consent of Shakley Chiropractic and Wellness Center and myself. I hereby revoke any previously signed authorizations, whether executed at this Office or any other office to the extent that the terms of those authorizations conflict with the terms of this Agreement.

I agree that each and every provision of this Agreement is reasonably necessary for the protection of the rights and interests of Shakley Chiropractic and Wellness Center and myself. However, should any provision of this Agreement be found to be invalid, illegal or unenforceable or for any reason cease to be binding on any party hereto, all other portions and provisions of this Agreement shall, nevertheless, remain in full force and effect.

Patient Name (Please Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Custodial Parent or Legal Guardian (Please Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_