



Lancaster Spinal Health Center

Authorization and Assignment

In Consideration of your undertaking to treat me, I agree to the following:

1. I authorize LSHC to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjustor in order to process any claim for reimbursement to charges incurred by me.
2. I authorize that direct payment be made to Lancaster Spinal Health Center for any sum, I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to reimburse me for the charges for your service or otherwise obligated to make payment to me or you based in whole or in part upon the charges made for your services.
3. In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the pertinent data below) and authorize you to prosecute said action either in my name or your name as you see fit and further authorize you to compromise, settle, or otherwise resolve said claim as you see fit.
4. I understand that whatever amounts you do not collect from insurance proceeds for **non-covered services** or whether it is all or part of what is due, I personally owe you.

Patient/Parent Signature _____
(If patient is under 18 a parent/guardian must sign)

Date ____/____/____