PATIENT VERIFICATION

IF YOU RECEIVE CHECKS FROM YOUR INSURANCE COMPANY

I am receiving health care services from Scott Mitchell, D.C. Chiropractic Inc. ("The Provider"). As a condition of receiving these services and to induce The Provider to wait for payment from my insurance companies, I have assigned my right to receive benefit payments from my insurance directly to The Provider. This Assignment cannot be cancelled.

I understand that my insurance carrier may issue checks to The Provider, to myself, or to the primary policy holder. In the event I receive any checks from my insurance carrier or from any insurance company or third party as a result of these services, I agree to deliver such checks to The Provider within 3 business days from the date of such receipt, and to endorse such checks to The Provider.

I understand that should I receive monies for such services which I do not deliver to The Provider,
I may be additionally responsible for attorneys' fees and punitive damages.

Date: _____

_____
Patient Name (please print)

_____
Patient's Signature