Strain
Chiropractic Clinic Prof LLC

Sarah Strain, D.C. Jona Stoebner, D.C. Brittany Van Overbeke, D.C.
2120 West Main St, Suite 1; Rapid City, SD 57702
Phone: 605-718-5720 Fax: 605-718-5721

Automobile Accident/Workman's Compensation/Personal Injury Claims

We do not accept third-party claims for automobile accidents or personal injury claims. *We will bill your automobile insurance med pay. You may wish to check with your own automobile insurance to see if you have med pay attached to your policy, and determine the total amount available (the "cap") is. After your cap is met and funds are exhausted, we will bill your health insurance or you personally, if you have no health insurance.*

Please be advised, we will hold all charges on your claim's account for 7 working days. If we have not received all the information from you needed to bill the claim after 7 days, all charges pertaining to this claim become your responsibility.

AA/WC charges for massage will be collected date of service. If your workman's compensation or automobile accident insurance case pays these charges, we will credit your account.

You will need to supply the following pieces of information.

- Claim number
- Claim adjuster company and address, Claim adjuster name, claim adjuster fax number and phone number
- Any other pertinent information
- Copy of your health insurance card. (We use this information to bill your health insurance if after 45 days we have no payment from your AA/WC/PI claim.)

PLEASE NOTE:

If after 45 days no payment for services received and/or we have been unsuccessful in obtaining a response from your supplied insurance, YOU WILL BE BILLED FOR THE OUTSTANDING CHARGES.

By signing this form you are acknowledging these terms and conditions.

Print Name

Signature Date

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Please furnish the following information so we can correctly bill your charges:

Attorney's Name: _____Phone:_____

Address:_____City_____State_____Zip_____

Your Insurance Company:_____

Claim number: _____

Address: _____City_____State_____Zip

Adjuster' Name: _____

Adjuster's phone:_____

Is there anything else we should know?

_____

_____

_____
Print Name

_____
Signature Date

IRREVOCABLE ASSIGNMENT AND AUTHORIZATION TO PAY INSURANCE BENEFITS, HEALTH INSURANCE, AUTO - MEDICAL PAYMENTS, AND/OR ATTORNEY

To Whom It May Concern:

I, _____, hereby authorize and direct you, my insurance company, and/or my attorney, to **pay directly to Strain Chiropractic Clinic, LLC,** any and all sums as may be due and owing me for services rendered to me by Strain Chiropractic Clinic, LLC, both by reason of accident or illness, and by reason of any other bills that are due this office. I further direct my insurance company, and/or my attorney to withhold such sums from any disability benefits, medical payment benefits, no-fault benefits, health and accident benefits, benefits, or any other insurance benefits and/or monies received and/or owing me from any payments received from any settlement, judgment or verdict on my behalf in an amount equal to any outstanding balance that is owed to Strain Chiropractic Clinic, LLC for my treatment. I hereby further irrevocably assign to Strain Chiropractic Clinic, LLC any and all insurance benefits named herein, and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by Strain Chiropractic Clinic, LLC, said assignment to be equal to any outstanding balance owed by me to Strain Chiropractic Clinic, LLC. This is to act as an irrevocable assignment of my rights and benefits to any monies owed or received for my benefit in an amount equal to any outstanding balance owed by me to the Strain Chiropractic Clinic, LLC. This said assignment is binding under South Dakota Codified Law (SDCL) 57A-9, SDCL 57A-9-102(46) and SDCL 57A-9-309 (5).

In the event my insurance company, or attorney are obligated to make payments to me for compensation of any claims, benefits, money owed, settlements and /or judgments, and the insurance company, attorney or any other party so obligated refuses to make such payments either upon demand by me or Strain Chiropractic Clinic, LLC, I hereby assign and transfer to Strain Chiropractic Clinic, LLC any and all causes of action that I might have or that might exist in my favor against such company and/or party, and authorize Strain Chiropractic Clinic, LLC to prosecute said cause of action either in my name or in Strain Chiropractic Clinic, LLC name. I further authorize Strain Chiropractic Clinic, LLC to compromise, settle or otherwise resolve such claim or cause of action as they see fit.

In the event I, my attorney, heirs, attorney-in-fact or any other person acting on my behalf, receives monies owed me for compensation of benefits, claims, money owed, settlements and /or judgments, I further agree that an amount equal to that which is owed to Strain Chiropractic Clinic, LLC by me for any treatment that I receive, shall be placed in trust for the benefit of Strain Chiropractic Clinic, LLC ,for which trust I or anyone that I so designate to be trustee, and Strain Chiropractic Clinic, LLC being the beneficiary. Said trust will be dissolved upon all amounts due and owing Strain Chiropractic Clinic, LLC) being paid to Strain Chiropractic Clinic, LLC.

I understand that I remain personally responsible for the total amounts due to Strain Chiropractic Clinic, LLC for their services. I further understand and agree that this Assignment and Authorization do not constitute any consideration for Strain Chiropractic Clinic, LLC to await payments and that they may demand payments from me immediately upon rendering services at their option.

I authorize Strain Chiropractic Clinic, LLC to release any information pertinent to my case to any insurance company, including adjuster or attorney to facilitate collection under this Assignment and

Authorization. I agree that Strain Chiropractic Clinic, LLC shall be given the Power of Attorney to endorse and/or sign my name on any and all checks for payment of any outstanding bill owed Strain Chiropractic Clinic, LLC.

I further understand and agree, that if Strain Chiropractic Clinic, LLC must take any action to collect an outstanding balance on my account, I will be responsible for payment of and will reimburse Strain Chiropractic Clinic, LLC for all costs of such collection efforts, including but not limited to all court costs and all attorney fees.
I also understand that interest will be charged on all balances 60 days past due.

I further direct that this Authorization and Assignment shall be binding upon my legal heirs, successors, assignees, legatees or any other party legally acting on my behalf.

Patient's Signature _____SS#_____ Date: _____

Guardian or Spouse's
Signature Authorizing Care _____ Date: _____