



**RELEASE OF AUTHORIZATION AND**  
**LETTER OF PROTECTION**

I, \_\_\_\_\_, hereby authorize this office to furnish my attorney, \_\_\_\_\_, and/or \_\_\_\_\_ Insurance Company, or the designee of either, any medical information requested concerning the condition or treatment of injuries sustained by me and/or my children, on \_\_\_\_\_.

I authorize and direct my attorney to pay from any insurance or other proceeds for any recovery made as a result of said injury; any unpaid balance due said doctor for professional services as a result of any treatment to myself, or my children. I understand that this in no way relieves me of my personal primary responsibility to pay my doctor for service when a statement is rendered and that I will receive customary billing for said services.

I authorize my attorney or any third party liability carrier to disclose the settlement status, settlement statement and/or a copy of the settlement check if requested for our purposes. At the time of the settlement, the attorney is instructed that this office shall be furnished separate checks for the medical services which they have rendered for full balance due at that time.

Upon settlement of the underlying, the attorney's office will disburse funds directly to Moran Signature Chiropractic, LLC . The patient hereby acknowledges that should the net recovery to the patient not be sufficient to pay in full all amounts due this office with respect to the above stated matter, then the patient shall remain personally responsible for any unpaid balance

1. I understand that I am being treated for injuries sustained in a motor vehicle accident and that failure to keep my appointments may jeopardize the insurance carrier's responsibility for medical costs and/or compensation for pain and suffering.
2. I understand that this office is extending me credit for treatment and that if I miss two (2) office visits without a reasonable excuse all bills may be due immediately.
3. I understand that if I sever ties with my attorney before settlement or my attorney will no longer represent my case, all bills may be due immediately.
4. Once released from care, if my case is not settled within six months I will begin making payments of \$50.00 a month to this office toward my bill.
5. If my bill is not paid within 30 days after the settlement, my balance will then be turned over to a collection attorney and all attorney's fees will be the responsibility of the patient.

SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

**ASSIGNMENT AND INSTRUCTION**  
**FOR DIRECT PAYMENT**

I hereby instruct and direct the \_\_\_\_\_ Insurance Company to pay by the check made out and mailed directly to:

Moran Signature Chiropractic, LLC  
Antontious L. Moran, Jr.  
Kimberly M. Moran  
750 Hammond Dr., Bldg 6, Suite. 150  
Atlanta, Ga. 30328

If my current policy prohibits direct payment to the doctor, then I hereby also instruct and Direct you to make out the check to me and mail it as follows:

See Above Address

For the professional or chiropractic expense benefits allowable and otherwise payable to Me under my current insurance policy as payment toward the total charges for Professional services rendered.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned Assignee, and I have agreed to pay, in a current manner, any balance of said professional Service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the Original.

I also authorize the release of any information of pertaining to my case to any insurance Company, adjuster, or attorney involved in this case.

Dated at this \_\_\_\_\_ day of \_\_\_\_\_ 20 \_\_\_\_.

\_\_\_\_\_  
Signature of policyholder

\_\_\_\_\_  
Signature of Claimant (if other than Policyholder)

## **MED PAY BENEFITS**

Many people have medical benefits (medical payments coverage or “Med Pay”) included in their automobile policies. This benefit would be listed on the Declarations Page (The “Dec Page”) of your insurance policy and it might also appear on the insurance card that you are required to carry as proof of insurance. Our office encourages you to use these benefits since you are already paying for them and since this is exactly their intended use: to provide for your needed medical care without your incurring any penalty, or having to pay a deductible.

Here are several reasons why we recommend that you use your med pay benefits:

1. Med Pay is exactly like health insurance in that using it does not cause your rates to increase. If your rates do increase it is not because you filed your med pay. Instead it is likely that: (a) the accident was determined to be your fault by your insurance company; (b) you received a police citation at the time of the police report; (c) you have been involved in numerous reported auto accidents within a brief period of time and you are now considered a “high risk”.
2. Filing your Med Pay does not relieve the other party from having to pay in full for your loss. Filing Med Pay will help to insure that you are not left to pay medical bills if the other driver’s insurance company refuses to make payment to you for any reason.

If for any reason your Med Pay account does not pay, we will advise you and you can choose to file on your major medical insurance at that time. Your account balance will still be your responsibility.

### **OUR OFFICE FINANCIAL POLICY**

As long as our office is filing your med pay and health insurance and as long as these companies are continuing to cover your charges, we will waive collection of payment from you at the time of service. If we receive overpayment on your account we will be happy to refund you the difference, provided we are not under a duty to refund the insurance company.

### **PAYMENT AGREEMENT**

I understand that I am being treated for injuries sustained in a motor vehicle accident. I am aware that I do not have medical coverage benefits (Medpay) on my automobile insurance policy which is the primary insurance in the event of an automobile accident. I further understand that my health care insurance becomes my secondary insurance in the event of an accident however your insurance company may not cover chiropractic care and they are not responsible for any bills incurred due to a motor vehicle accident that are on an attorney lien or may be in the process of litigation and may deny all claims.

After reading the above statements I am fully aware that I am responsible for any bills incurred for the treatment due to the motor vehicle accident and I am also aware that Moran Chiropractic, LLC is extending me a credit for treatment until my settlement is complete. Once released from care and I have settled my case I agree to come in within 10 days and pay my balance in full.

\_\_\_\_\_  
Patient Name (Printed)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Witness

Date \_\_\_\_\_/\_\_\_\_\_/20\_\_\_\_\_