IRREVOCABLE ASSIGNMENT OF PERSONAL INJURT PROCEEDS

RE: Patient Name:
Date of Loss:
Provider:
Law Firm:

The undersigned patient fully understands that the undersigned is, and remains, directly and fully responsible to the above stated Provider for all billings submitted by the Provider for health care services rendered to the undersigned. This responsibility is not absolved in any manner by the result of any first part or third party claim (Claim) made by the undersigned. In the even that any claim is not successful, in whole or in part, I will be responsible to make arrangement to pay the undisputed Provider's/Creditor's billings subsequent to the claim's termination by the court order, settlement or operation of law.

The undersigned hereby authorizes and direct Law Firm to pay directly to the aforementioned Provider, or their assignee, such sums from the undersigned's share of any personal injury proceeds, awards or settlements as may be due and owing for health care services rendered to him/her whether by reason of the subject occurrence or otherwise. If there are inadequate proceeds, I direct Law Firm to allocate my share of the personal injury recovery (not including attorneys fees and costs) to perdected lien interest in accordance with statutory guidelines, and any remaining balance pro rata to any debts unsecured by liens. The Law Firm has no further responsibility. I further consent to a lien being filed with respect to the above claim against the appropriate portion of the undersigned's share of proceeds of any settlement or judgment which may be pain to my attorneys. I acknowledge that if the amount payable under any statutory lien is inadequate to pay the entire balance owed, that I remain liable for any such undisputed and unpaid balance, notwithstanding any acceptance of limited payment and subsequent release of such lien, unless such accord and satisfaction is agreed to by the Provider.

I understand that signing this assignment and guarantee is voluntary on my part. I direct Law Firm to hold in trust or interplead into an appropriate court any disputed sums in the event of any attempt by the undersigned to rescind these instruction. In the event that my current attorney withdraws and another attorney is substituted in their place and stead, then I direct such substitute or new council to honor these instructions upon receipt of a signed copy of such instructions. If I choose an attorney or already have an attorney that is not recognized by said Provider, I understand that if my personal injury insurance or Med Pay has been exhausted, or I have no personal injury protection or Med Pay, that payment in full is required by the end of each month.

I also understand that I am directly and fully responsible to said Provider or his/her office for all health care expenses incurred for services rendered to me. Any auto or third party claim where the patient discontinues care or is not following the recommendations of said Provider understands that payment is due in full beginning on the last day of care or when care is reduced by the patient and not the Provider.

I have been made aware that if my attorney does not wish to cooperate in protecting said Provider and his office, the Provider will not await payment, but will require me to pay in full each month and that I will seek payment from my attorney when the claim is settled.

Signature of Patient _____ Date _____
Patient's Drivers License Number _____ State _____
Patient's Social Security Number _____

The undersigned attorney for the above patient/client, subject to the Rules of Professional Conduct 1.14, and Formal Opinion 185, does acknowledge this irrevocable assignment of the patients/clients share of settlement or judgment proceeds and the undersigned will comply with the patient's/client's instructions to with hold sums from the patient's/client's share of proceeds to assure payment to the Provider/Creditor. Nothing herein creates any personal obligation whatsoever on the part of the undersigned attorney to pay any obligations of the patient/client from any other source than client funds remaining after deduction of any attorney fees and costs. If the patient files for bankruptcy protection, the validity of this assignment shall be determined by the Bankruptcy Court.

Dated: _____ By: _____

Attorney

Attorney Signature: _____

CONTRACTUAL GUARANTEE OF PAYMENT FOR HEALTH CARE SERVICES

I hereby authorize and direct you, my attorney, to pay directly to Cascade Chiropractic such sums as may be due and owing for health care services for injuries arising from a motor vehicle accident which occurred on **this date** _____. I hereby authorize my attorney and involved insurance companies to withhold sums from any settlement, judgment or verdict as may be necessary to adequately protect said Chiropractor or his office. I hereby further consent to a lien being filed on my case by said Chiropractor or his office against any proceeds of settlement, judgment or verdict which may be paid to you, my attorney or myself as the result of the injuries for which I have been treated.

I agree to never rescind this document and that any attempted rescission will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney shall honor this Contractual Guarantee of Payment of Health Care Services as inherent in the settlement and enforceable upon the case if it were executed by him/her.

I fully understand that I am directly and fully responsible to said Chiropractor or his office for health care bills submitted by him for services rendered me. **ANY AUTO OR THIRD PARTY TYPE CLAIM WHERE THE PATIENT DISCONTINUES ARE OR IS NOT FOLLOWING TREATMENT RECOMMENDATIONS, PAYMENT IN FULL IS DUE ON A MONTHLY BASIS BEGINNING ON THE LAST DAY OF CARE OR WHEN THE PATIENT REDUCES HIS OR HER OWN CARE.**
Initials of patient: _____

Further, this agreement is made solely for said Chiropractor's additional protection and in consideration of his forbearance on payment. I also understand that such payment is not contingent on settlement, judgment or verdict by which I may eventually recover damages.

I specifically request that my attorney acknowledge this letter by signing below and returning to said Chiropractor's office. I have been advised that if my attorney does not wish to cooperate in protecting the chiropractor and his office's interest, the chiropractor will not await payment and will require me to pay my balance in full each month.

Date _____ Signature of Patient _____
Driver's License Number _____
Patient's Social Security Number _____

The undersigned, being attorney of record for the above patient, does hereby agree to observe all the terms of the above, and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said Chiropractor named above.

Date _____ Signature of Attorney_____

Please date, sign and return the original to the address below.

Cascade Chiropractic
949 East Main Street
Auburn, WA 98002