Treanor Chiropractic Wellness Center
4161 Capital Drive, Rocky Mount, NC 27804
Office: 252-210-3490 Fax: 252-210-3489

To any insurance company with coverage applicable to my claim(s) and to any attorney representing me:

ASSIGNMENT OF BENEFITS

IN CONSIDERATION of the willingness of *Treanor Chiropractic Wellness Center* to treat me on credit without demand for payment at the time services are rendered, I hereby agree and stipulate as follows:

I irrevocably assign to *Treanor Chiropractic Wellness Center* any proceeds or compensation that I am or may become entitled to receive as a result of injuries that occurred on _____ to the extent of the chiropractic services rendered. I make this agreement without prejudice to any rights I may have to prosecute legal claims against any party who may be liable for my injuries, but I hereby authorize and instruct you to pay directly to *Treanor Chiropractic Wellness Center*, from any disability benefits, medical payments benefits, liability benefits, health and accident benefits, workers compensation benefits, judgments, settlements, or proceeds of any kind that would otherwise be payable to me, such sums as are due to *Treanor Chiropractic Wellness Center* for its services rendered.

I appoint *Treanor Chiropractic Wellness Center* as my attorney in fact to affix my name as an endorsement upon the reverse of any check or draft upon which I am a named payee and to deposit said check or draft and apply the proceeds to any unpaid balance I may have with *Treanor Chiropractic Wellness Center*.

I authorize *Treanor Chiropractic Wellness Center* to release to any insurer with applicable coverage or to my attorney or successor attorney any information regarding my injuries, prior medical history, or treatment as may be necessary to facilitate collection of proceeds under this assignment. **I authorize the use of a copy (including an electronic or faxed copy) of this form.**

I acknowledge that I remain personally liable for the total amount due to *Treanor Chiropractic Wellness Center* for services rendered, including any balance remaining after the application of insurance payments and settlement or judgment proceeds. If *Treanor Chiropractic Wellness Center* is required to take legal action against me to recover any unpaid balance on my account, I agree to reimburse *Treanor Chiropractic Wellness Center* for its costs of recovery, including reasonable attorney's fees.

I further agree this assignment of benefits (AOB) cannot be revoked and the right to receive payment cannot be transferred to any other party or re-asserted by me in any way.

_____ _____
Patient Parent or Guardian *(if applicable)*

_____ _____
Witness Date

NOTICE OF LIEN

Pursuant to N.C.G.S. 44-49 and 44-50, *Treanor Chiropractic Wellness Center* hereby asserts and gives notice of a lien upon any sums recovered in damages for personal injury in any civil action and also upon all funds paid to the above-named patient in compensation for or settlement of injuries sustained, whether in litigation or otherwise.

Treanor Chiropractic Wellness Center hereby requests that if its claim is not paid in full from the foregoing proceeds, a full disclosure and accounting of proceeds be provided in conformity with N.C.G.S. 44-50.1. *Treanor Chiropractic Wellness Center* agrees to be bound by any confidentiality agreements regarding the contents of the accounting.

Treanor Chiropractic Wellness Center

By: _____ Date:_____