

Enclosed: Assignment of Proceeds, Lien and Authorization

**Advanced Healthcare
191-A. West Plaza Drive
 Mooresville, N.C. 28117**

Assignment of Proceeds, Lien, and Authorization

Claim or File#: _____ Insured's Name: _____ Loss Date: _____
Patient: _____ Policy#: _____

I hereby authorize and direct any and all insurance carriers, attorneys, agencies, governmental departments, companies, individuals, and/or other legal entities ("payers"), which may elect or be obligated to pay, provide, or distribute benefits to me for any medical conditions, accidents, injuries, illnesses, past, present, or future ("condition") to pay directly and exclusively to **Advanced Healthcare, (herein "A.H.C.")**, such sums as may be owing to **A.H.C.** for charges incurred by me at the Office relating to my condition ("charges"), with such payments to be made exclusively in the name of **Advanced Healthcare**. I further grant a lien to **A.H.C.** with respect to my charges. This lien shall apply to all payers and to the full extent permitted by law. For the purposes of this document (herein "Assignment and Lien"), "benefits" shall include, but not be limited to, proceeds from any settlement, judgement, or verdict, as well as any proceeds relating to commercial health or group insurance, medical payment benefits, personal injury protection, no fault coverage, uninsured and underinsured motorist coverage, third-party liability distributions, disability benefits, worker's compensation benefits, and any other benefits or proceeds payable to me for the purpose stated herein.

I authorize this Office to release any information regarding my treatment or pertinent to my case(s) to all payers as defined above to facilitate collection under this Assignment and Lien. I further authorize and direct all payers to release to **A.H.C.** any information coverage or benefits which I may have including, but not limited to, the amount of coverage, the amount paid thus far, and the amount of any outstanding claims. I hereby direct this Office to file a copy of this Assignment and Lien, together with any applicable charges, with any or all payers, regardless of whether a claim has been established with said payers. I hereby grant **A.H.C.** power of attorney to endorse/sign my name on any and all checks listing me as payee which are presented to this Office for payment of an account relating to me, my spouse or any of my dependents. I further authorize **A.H.C.** to apply any credit balances on charges incurred by me to any other outstanding charges still owed by me, my spouse, or my dependents, regardless of these other charges are related to my condition. I hereby give permission and authorize disclosure of any disbursement of settlement funds involved in this case to **A.H.C.**

I understand that I remain personally responsible for the total amount due to **A.H.C.** for their services. This Agreement does not constitute any consideration for this Office to await payments and it may demand payments from me immediately upon rendering services at its option. If this Office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse **A.H.C.** for all costs of such collection efforts, including but not limited to, all court cost and all attorney fees.

This Agreement shall not be modified or revoked without the mutual written consent of **A.H.C.** and myself. I hereby revoke any previously signed authorizations, whether executed at this office or any other office to the extent that terms of those authorizations conflict with the terms of this Agreement.

I agree that each and every provision of this Agreement is reasonably necessary for the protection of the rights and interests of **A.H.C.** and myself. However, should any provision of this Assignment be found to be invalid, illegal, or unenforceable, or for any reason cease to be binding on any part hereto, all other portions and provisions of this Assignment shall, nevertheless, remain in full force and effect.

Patient Name (please print): _____
Patient Signature: _____ Date: _____
Name of Custodial Parent or Legal Guardian (please print): _____
Parent/Guardian Signature: _____