

# Mohammadi Chiropractic Clinic

Dr. Zahra Mohammadi

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CARY, NC 27519

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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 **Mohammadi Chiropractic Clinic** 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 **Mohammadi Chiropractic Clinic** 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 **Mohammadi Chiropractic Clinic**, from any disability 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 as are due to **Mohammadi Chiropractic Clinic** for its services rendered.

I appoint **Mohammadi Chiropractic Clinic** 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 am have with **Mohammadi Chiropractic Clinic**.

I authorize **Mohammadi Chiropractic Clinic** to release to any insurer with applicable coverage or to my attorney or successor attorney any information regarding my injuries, prior medical history as may be necessary to facilitate collection of proceeds under this assignment.

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

Patient's Name: \_\_\_\_\_ SSN#: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Parent or Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Witnessed by: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## NOTICE OF LIEN

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

**Mohammadi Chiropractic Clinic** 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. **Mohammadi Chiropractic Clinic** agrees to be bound by any confidentiality agreements regarding the contents of the accounting.