ASSIGNMENT, LIEN AND AUTHORIZATION
INSURANCE BENEFIT AND ATTORNEY
INTEREST CHARGES AGREEMENT

To Whom It May Concern:

I hereby authorize and direct you, my insurance company, and/or my attorney to pay directly to Dr. Edward J. Peeks, d/b/a Peeks Chiropractic Office, 401 Boone St., Johnson City, TN 37604 such sums as may be due and owing Dr. Peeks' office for services rendered to me, both by reason of accident or illness and by reason of any other bill that are due Dr. Peeks' office and to withhold such sums from any disability benefits, medical payment benefits, "No-Fault" benefits, health and accident benefits, workman's compensation benefits or any such insurance benefits obligated to reimburse me or from any settlement, judgment, or verdict on my behalf as may be necessary to adequately protect Dr. Peeks' office. I hereby further give a lien to Peeks Chiropractic Office against any and all insurance benefits names herein, and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by Peeks Chiropractic Office. This is to act as an ASSIGNMENT of my rights and benefits to the extent of the Peeks Chiropractic Office services provided.

In the event my insurance company, who is obligated to make payments to me based upon the charges by Peeks Chiropractic Office, for their services, refuses to make such payments, upon demand by me for Peeks Chiropractic Office, I hereby assign and transfer to Peeks Chiropractic Office any and all causes of action that I might have or than might exist either in my name or in the name of Peeks Chiropractic Office and I further authorize Peeks Chiropractic Office to compromise, settle or otherwise resolve said claims or cause of action as they see fit.

I understand that I remain personally responsible for the total accounts due to Peeks Chiropractic Office for their services. I further understand and agreement that this Assignment, Lien and Authorization do not constitute a consideration for Peeks Chiropractic Office to await payments and that Peeks Chiropractic Office may demand payments of me immediately upon rendering services, at their option.

I further authorize and agree to pay any finance charges that may be applied to any outstanding balance that I may accrue. I acknowledge that the interest rate will not exceed ***18% (1.5% monthly APR)*** *and may be less than* ***18%.***

Peeks Chiropractic Office has the right to impose an interest rate on my outstanding balance 30 days from the start of my balance. That is to say, 30 days after a bill has been presented to me as either an unpaid portion of my insurance claim such as a deductible or co-pay or other charges not covered by my insurance or any charges for services or goods that I have received as part of my health care at Peeks Chiropractic, the amount of the bill, at that time, will be subject to interest rate charges.

As an example, a statement is issued on March 1. On April 1, if the outstanding balance has not been paid, the remaining balance will be subject to interest rate charges. The interest charges will start April 1st and be added to the balance. Both the balance and interest charges will be due on the next billing cycle.

Furthermore, by signing this document I understand that if a insurance claim is not paid in two attempts/cycles by Peeks Chiropractic Office (to file a claim for covered services that I have received at Peeks Chiropractic Office) I will pay for those services and will take responsibility for any further reimbursement procedures with my insurance company. If my insurance company eventually pays the delinquent claim, and I have paid for those services, any funds sent to Peeks Chiropractic Office will be reimbursed to the patient upon receipt of those funds from the insurance company.

I authorize Peeks Chiropractic Office to release any information pertinent to my case to any insurance company, adjustor or attorney to facilitate collection under this Assignment, Lien, and Authorization. I agree that Peeks Chiropractic Office be give Limited Power of Attorney to endorse/sign my name to any and all checks for payment of my bill for services rendered by Peeks Chiropractic Office. I hereby waive the statute of limitation regarding the physician's right to recover.

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Signature of Patient *Date Signed*

______________________________ __________

Witness *Date Signed*

Date of injury ______________________

Name of Insurance Company ______________________

Policy # ______________________________

Name of Attorney ____________________________