HOLISTIC CENTER FOR Vibrant Health
Your Partners in Creating a Dynamic Life

ASSIGNMENT AND AUTHORIZATION

For good and valuable consideration, including the agreement of Holistic Center for Vibrant Health to accept this assignment in lieu of demanding full payment for services from the undersigned on the date each service is rendered, the undersigned patient executes this document hereby assigning to Holistic Center for Vibrant Health the right to receive insurance benefits directly from any insurance company that may be obligated to provide insurance benefits, to me or on my behalf, for services rendered by Holistic Center for Vibrant Health, for a motor vehicle accident that occurred on or about _____.

Any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, for the aforesaid accident for services provided by Holistic Center for Vibrant Health, is hereby directed to issue payment for those benefits directly to and payable to Holistic Center for Vibrant Health.

I also authorize and assign Holistic Center for Vibrant Health the right to file suit and pursue all legal remedies to obtain payment for services provided to me by Holistic Center for Vibrant Health. This authorization to file suit is an assignment of my cause of action to obtain payment for services provided to me by Holistic Center for Vibrant Health and includes the assignment to pursue declaratory relief or any other legal remedies.

Holistic Center for Vibrant Health accepts the aforesaid assignment and hereby notifies any insurer issuing payment that Holistic Center for Vibrant Health objects to any "repricing" or reduction of billed amounts unilaterally made by any insurer. Any such reduced payments issued by any insurer are accepted under protest and without waiving any right of the provider to pursue all legal remedies against the insurer.

Please read this document completely before signing. If you do not completely understand this document or have any questions about this document, please ask us to explain it to you. If there is any portion of this document that you do not wish to authorize, we will remove that portion from this document. Your signature below is your agreement you fully understand this document and you fully agree to the terms of this document.

_____ _____
Patient Signature (or Guardian) Date

_____ _____
Witness to Patient or Guardian's Signature Date

_____ _____
Authorized Signatory for Medical Provider Date