Lissa A. Grannis, D.C., DACS
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ASSIGNMENT AUTHORIZATION
POWER OF ATTORNEY & AGGREEMENT

In that the office is waiting for the payment of some or all of its fees, I agree to provide the office with information and forms regarding any potential source of fee payment, to assist in any way I can, and,

1. I hereby assign to this office my rights to receive payments from negligent parties or from insurance companies. Payments should be payable to and mailed to:

   Creekside Chiropractic & Massage
   6210 75th St W, Suite A100
   Lakewood, WA 98499

   If my policy prohibits assignments, then check should be payable to me and sent to above address.

2. I understand that if this office receives more than their fees, the office will pay any credit balancesto me, the PATIENT.

3. I authorize the office to release any information to any insurance company, adjuster, or attorney that will assist in the payment of a claim.

4. I appoint this office as attorney-in-fact to correspond in my behalf with insurance companies, to negotiate any settlement and to cash any settlement draft or check. Counsel, insurance companies, and negligent parties be advised that, no settlement can be effectuated without the aggreement of this office or the office's release of this specific provision. Said negotiation to be for the payment of health expenses and will not release negligent party from other responsibilities. The office does not intend to "represent" me in any way, this appointment is strictly to prevent negligent parties, attorneys or insurance companies from settling any financial relations with me without fulfilling my financial responsibilities to this office first.

5. I fully understand and agree that insurance policies are an arrangement between an insurance carrier and myself. I will be responsible for any expenses not paid by insurance.

6. If the office incurs any attorney fees or other collection expense for the collection of this account because I have not complied with this aggreement I understand that I will be responsible for those fees or expenses in addition to the health fees.

7. A photocopy of this form shall be as valid as the original.

_____ _____
Date Patient

_____ _____
Information Taken By Responsible Party

(253) 588-1800 Bus
(253) 588-8781 Fax
6210 75th St. W., Suite A100
Lakewood, WA 98499-8108