

**POWER OF ATTORNEY AND ASSIGNMENT OF BENEFITS FORM**

**POWER OF ATTORNEY TO ENDORSE CHECKS AND/OR SIGN ANY PAPER WHICH WILL ENHANCE OR EXPEDITE PAYMENT TO PROVIDER FOR SERVICES RENDERED, INCLUDING, BUT NOT LIMITED TO A RELEASE OF MEDICAL RECORDS and ASSIGNMENT OF BENEFITS/AUTHORIZATION TO PAY.**

Know by all these present that: The undersigned has made, constituted and appointed, and by these presents does hereby make, constitute and appoint ARCADIA CHIROPRACTIC CLINIC, Inc. and any of its duly authorized agents and employees as and to be the undersigned's true and lawful attorney for and in the undersigned's name, place and stead to endorse any and all checks, drafts or money orders which are made payable to the undersigned alone or to the undersigned and the said ARCADIA CHIROPRACTIC CLINIC, Inc. which checks, drafts or money orders are made payable for services which have been made by ARCADIA CHIROPRACTIC CLINIC, Inc. at the request or with the knowledge and approval of the undersigned and/or the maker of the check, draft or money order.

Futhermore, the undersigned allows ARCADIA CHIROPRACTIC CLINIC, Inc. or any of its agents to sign any paper that will be necessary to enhance, expedite and/or allow payment to said provider. This may include affidavits of non-ownership of vehicles, insurance forms and other statements.

The undersigned by these presents does give and grant the said ARCADIA CHIROPRACTIC CLINIC, Inc. as attorney the full power and authority to do and perform all and every act whatsoever requisite and necessary to be done in and about the premises as fully to all intents and purposes as the undersigned might or could do to personally present insofar as the endorsing and cashing of said checks are concerned as well as any other document.

**MEDICAL RELEASE**

A photocopy of this document shall be sufficient to authorize any person having records of medical treatment, services or supplies pertaining to me to release true copies of same to ARCADIA CHIROPRACTIC CLINIC, Inc. or any insurer providing coverage to me in connection with the processing of any claim for benefits made by me or by the assignee herein.

A photocopy of this document shall be as binding as an original signature page.

The undersigned does hereby ratify and confirm any and all actions taken by the said attorney in accordance with this special power and which the said attorney shall do or cause to be done by virtue of these presents.

**Release of Information:** I hereby authorize this medical provider to: furnish my insurance company or companies and the patient's attorney with any and all information that may be contained in my medical records; to obtain coverage information telephonically from my insurer; to request a written non-redacted PIP payout sheet from the insurer; and to obtain copies of my medical records, including but not limited to, documents, reports, scans, notes, opinions, X-rays, and MRI's received from any other medical provider or any insurance company. The insurer is directed to keep the patient's medical records private and confidential. The insurer is NOT authorized to provide these medical records to anyone, including but not limited to, third party vendors without the patient's and the provider's prior express written permission.

**ASSIGNMENT OF BENEFITS:**

I, \_\_\_\_\_ hereby authorize \_\_\_\_\_ to:  
(Name of Insured) (Name of Insurance Carrier)

Payable directly to: ARCADIA CHIROPRACTIC CLINIC, INC.  
Payable to and mailed directly to: ARCADIA CHIROPRACTIC CLINIC  
936 N. MILLS AVE.  
ARCADIA, FL 34266

The medical benefits are otherwise payable to me for their services, but not to exceed the charges of those services. I hereby IRREVOCABLY ASSIGN to ARCADIA CHIROPRACTIC CLINIC, Inc. any benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statutes for any services and or charges provided by ARCADIA CHIROPRACTIC CLINIC, Inc.

**IN WITNESS WHEREOF** the undersigned have hereunto set their hands, this \_\_\_\_\_ day of \_\_\_\_\_, 2006.

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PATIENT/GUARDIAN SIGNATURE

PATIENT'S NAME (PLEASE PRINT)