



**Irrevocable Assignment, Lien and Authorization
Insurance Benefits, and Attorney, and Private Pay**

I, _____ hereby authorize and direct you, my insurance company, and/or my attorney, to pay directly to At Ease Massage Therapy such sums as may be due and owing this Office for services rendered me, by reason(s) of accident or illness, by reason of any other bills that are the Office and withhold such sums from any disability benefits, medical payment benefits, no fault benefits, health and accident benefits, or any other insurance benefits obligated to reimburse me from my 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 At Ease Massage Therapy.

In the event my insurance company obligated to make payments to me upon the charges made by this Office for their services refuses to make such payments, upon demand by me or this Office, I hereby assign and transfer to this Office and causes of action that I might have or that might exist in my favor against such company and authorize this Office to prosecute said cause of action either in my name or in the Office's name and further I authorize this Office to compromise, settle, or otherwise resolve such claim or cause of action as they see fit.

I understand that I remain personally responsible for the total amounts due At Ease massage Therapy for their services, I further understand the agreement that this Assignment, Lien and Authorization does not constitute any consideration for this Office to await payments and this Office demand payments immediately upon rendering services at their option.

I authorize At Ease Massage Therapy to release any information pertinent to my case to any insurance company, adjuster, or attorney to facilitate the collection under this Assignment, Lien and Authorization. I agree that At Ease Massage Therapy be given power of attorney to endorse/sign my name on any and all checks for payment of my treatment bill.

If I do not have any insurance coverage, I agree to make payment in full at the time of services rendered. Payment make by me by check, cash or major credit card. Any returned check will be subject to a \$35.00 service charge. Arrangements may be made for payments if needed, at the discretion of At Ease Massage Therapy.

I further understand and agree that if At Ease Massage Therapy must take actions to collect an outstanding balance on my account, I will be responsible for payment of and will reimburse this Office for all costs of such collection efforts, including, but not limited to, all attorney fees and court costs.

Printed Name: _____ Signature: _____ Date: _____