WINER WELLNESS CENTER
Acceptance of Financial Responsibility

Dr. James H. Winer, D.C.
Director

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I hereby authorize and direct you, the insurance company, and/or my attorney, to pay directly to WINER WELLNESS CENTER such sums that may be due and owing this office for services rendered to me, both by reason of accident, of illness and by reason of any other bills that are due this office, and to withhold such sums from any disability benefits, medical payment benefits, liability benefits, health and accident benefits, workmen's compensation benefits, or any other insurance benefits obligated reimburse me or from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect WINER WELLNESS CENTER. I hereby further give a lien to WINER WELLNESS against any and all insurance named herein, and any and all proceeds of any settlement, judgment or verdict that may be paid to me as a result of the injuries or illness for which I have been treated by said office. This is to act as an assignment of my rights and benefits to the extent of the office's services provided.

I understand that I remain personally responsible for the total amounts due the office for their services.

I further understand and agree that this assignment, lien and authorization does not contribute any consideration for the office to await payments and they may demand payment from me upon rendering services at their option. I authorize this office to release any information pertinent to my case to any insurance company or attorney to facilitate collection under this assignment, lien and authorization. I agree that the above mentioned office be given power of attorney to endorse my name on any and all checks for payment of my doctor bill.

I further understand and agree, that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment of and reimburse this office for all costs of such collection efforts including but not limited to all court costs and attorney fees. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment, but will require me to make payments on my current balance.

Please acknowledge this letter by signing below.

Name_____ Date_____