Dr. Pam Wilson
Healing Bodies. Changing Lives.

ASSIGNMENT AND RELEASE

130 Maple Ave., Suite 7A
Red Bank, NJ 07701
Phone: 732-842-7004
Fax: 732-842-8799

Patient Name (print): _____

- I authorize release of information to family physicians and employer.
- I authorize the taking of x-rays to be used for treatment purposes.
- I authorize the performance of other diagnostic and therapeutic procedures for treatment purposes.
- I authorize release of information to insurance companies.
- I authorize Wilson Physical Medicine, LLC/Dr. Pamela Wilson (chiropractor) to file insurance claims on my behalf for services rendered to me.
- I authorize my insurance company to release to Wilson Physical Medicine, LLC/Dr. Pamela Wilson, all information relating to any pertinent claims submitted by Wilson Physical Medicine, LLC/Dr. Pamela Wilson.
- I authorize my insurance benefits to be paid directly to:
  Wilson Physical Medicine, LLC/Dr. Pamela Wilson
  130 Maple Avenue, Suite 7A
  Red Bank, NJ 07701

I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier and myself. Therefore, I acknowledge that I am financially responsible for covered services not paid within 60 days, and for all non-covered services. I also understand that if I terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature _____ Date _____

TREATMENT OF MINOR

I hereby authorize Dr. Pamela Wilson to perform diagnostic tests and to administer treatment as she deems necessary to my (indicate relationship of child) _____, (child's name) _____.

Guardian's Signature _____ Date _____

ATTORNEY REPRESENTATION AND PROTECTION OF BALANCE

I, the undersigned, am directing my attorney, _____, to pay any outstanding bills from my settlement to Wilson Physical Medicine, LLC/Dr. Pamela Wilson. I fully understand that I am ultimately responsible for all medical bills and this agreement is made solely for the doctor's additional protection and consideration of her awaiting payment. I further understand that such payment is not contingent on my settlement, judgment or verdict by which I may recover said fee. 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 payment on a current status.

Patient's Signature _____ Date _____