# PARTIAL ASSIGNMENT OF CAUSE OF ACTION, ASSIGNMENT OF PROCEEDS, CONTRACTUAL LIEN AND TREATMENT AGREEMENT

Consideration. In order to facilitate the ability of the Office to collect in Charges directly from various Payers and thereby to enhance the patient provider relationship, I the undersigned, as consideration for the Offices services, agree to the following and direct all Payers as Follows.

Partial Assignment of the Cause of Action, Assignment of Proceeds, and Contractual Lien. I hereby assign, in so far as permitted by law, all of my rights, remedies, benefits to the office as well as any and all causes of action that I might have now or in the future against any Payer to the extent of my charges, the right to prosecute such cause of action either in my name or in the office's name, and the right to settle or otherwise resolve such causes of action as the office sees fit. I further assign my right to receive any proceeds from any payer to the office and further grant a contractual lien to the office with respect to my charges. I further assign my right to receive any proceeds from any payer to the office and further grant a contractual lien to the office with respect to my charges. I understand that these assignments of rights and contractual lien may effectuate, automatically or otherwise, a secured interest under the uniform commercial code. I intend for this agreement to effectuate such a lien and herby authorize the office to file the form(s) normally filled with the secretary of state and other government agency in order to perfect such lien. Except as provided herein, nothing in this agreement shall be construed as an election or waiver by the office to a secured interest under any other statutory lien law. If my account is referred to an attorney for collection of an outstanding balance, I agree to pay an attorneys fee equal to 33 and 1/3% of my outstanding balance (principle and interest) owed at the time of the referral. Consistent with these rights, I hereby direct any and all payers, to pay to proceeds directly and immediately to, and exclusively in the name of, deBarros Chiropractic Clinic in the amount of my charges.

Other terms, I understand that I remain personally responsible for my charges. Consistent with law or contract, I agree to pay the full amount of my charges of the office upon its demand. Unless mutually agreed to in writing, the receipt ad processing of partial payments by the office shall not constitute a waiver of the offices right to receive payment in full upon demand and shall not constitute an accord and satisfaction of my charges, irrespective of any restrictions indicated on any payments. I understand that at anytime, I can request a copy of my total charges. I hereby waive any statue of limitations that may apply to the collection of my charges. I understand that payment in full is due at the time that services are rendered. However, I agree to pay a finance charge of 1.5% per month (18.0% per annum) on balances over 30 days past due.

In the event that I retain one or more attorneys to assist me in collecting any proceeds, I direct each attorney to issue irrevocable letter of protection to the office regarding my charges. I further direct (and deBarros Chiropractic Clinic hereby requests) each attorney to provide immediate notice to the office regarding any proceeds received by the attorney, to promptly pay to the office in full out of such proceeds, and to provide a full accounting of such proceeds to the office.

I authorize and direct the office to submit my charges to any and all payers including, without limit, my health benefit plan. I understand, however, that in the event that my charges submitted to more than one payer, I hereby authorize and direct the office to apply any proceeds received from one or more payer to any reductions, write-offs, or discounts, issued by another.

I authorize the office to endorse or sign my name on any and all check listing me as the payee which are received by the office for payment of charges incurred by me, my spouse or my dependents. I further authorize the office to apply any credit balances on my charges to any other outstanding charges still owed by my spouse, my dependents, regardless of whether these other charges are related to my condition or me.

This agreement shall not be modified or revoked without the mutual consent of the office and myself. Io hereby revoke the terms of any previously signed documents to the extent those terms and agreement. This agreement shall be governed under the laws of the state where the office is located, and performable in the county where the office is located. I hereby consent to personal jurisdiction and venue of any court in said county and waive all objection based on improper jurisdiction, venue, or forum non-conventions.

I agree that that each and every provision of the agreement is reasonable necessary for the protection of the rights and interest of the office and myself. However, should any provision of this agreement be found "invalid, illegal and unenforceable, or for any reason cease to be binding on any party hereby, all other portions and provisions of this agreement shall, nevertheless, remain in full force and effect. A photocopy of this contract shall be considered as valid as the original.

Definitions. For the purpose of this Agreement, the following terms shall have the following meaning: "Office shall refer to: deBarros Chiropractic Clinic located at 7020 Cold Harbor Road, Mechanicsville, VA 23111. "Payer" shall refer to, without limit, any insurance carrier, health benefit plan administrator, and fiduciary, health maintenance organization, preferred and independent provider organization, attorney at fault, party, tortsfeasor, individual, and any other entity, which may elect or be obligated to payer disburse proceeds to me, either now or in the future, for any reason; "proceeds" shall include, without limit the proceeds from any settlement, judgment, or verdict, the proceeds from any promise to payer reimburse, in the proceeds relating to the following benefits, plans, or overages: individual and group health benefits, Medicare, Medicaid, workers' compensation, disability, liability, uninsured and underinsured motorist, no-fault, medical payments benefits, personal injury protection, lost wages, lost services, property damage and malpractice; "charges" shall include, without limit, the full fees for the offices services (including, without, limit, treatment, medical equipment, supplies, supplements, narrative reports, depositions, and testimony) any collection cost incurred by the office, 18% interest on outstanding charges, and any other charges incurred by me at the office; "collection cost" shall include, without limit, any pre and post judgment court cost, filling fees, service or process charges, attorneys fees, and any other cost of collection incurred by the office in any effort or action to collect my charges either from me or any payer.

Patient Name (Print) _____

Patient Signature _____ Date_____

Name of Custodial Parent or Legal Guardian, on Behalf of the Patient

Parent or Guardian Signature_____ Date_____