AUTO/ACCIDENT PAYMENT RESPONSIBILITY POLICY
IRREVOCABLE ASSIGNMENT/LIEN AND AUTHORIZATION

BODYWORKS

Please take a moment to review this summary. It provides an overview of our billing policy regarding auto and accident claims, and describes the information BODYWORKS will need to help you receive payment for the therapy you receive.

- **It is our company policy to bill your auto Insurance as long as medical payment benefits are available under your policy coverage.** In non-motor vehicle accident cases, your Home Owner's Policy may be billed. In situations where fault needs to be determined, the auto/accident insurance carriers will make appropriate re-disbursements of funds *after* fault is determined.
- **BODYWORKS will need the name and phone number of the adjuster assigned to your auto/accident claim.** You will need to bring in the notice of a filed accident claim from your insurance carrier, along with your adjusters contact information, and the amount of Medical Payment on your policy. We will call this individual to verify your policy and the insurance address to send your bills to.
- Payment for services is expected as your auto carrier is billed. If your carrier's policy is to delay payment until treatment is ended, or should you obtain an attorney during your care, and your insurance carrier stop payments, you will be responsible for payment at time of service. We can provide you with copies of your daily encounters to give to your attorney to show medical expenses paid.
- **When medical payment benefits are not available on your policy, we can create a contract that defines monthly payments** that are comfortable for you and reasonable for us. We do not wish to add to your distress after an accident. Payment arrangements should be made with the Billing Office during your Patient Orientation.
- **Although you may have consulted with and have an open pending legal case with an attorney, we do not typically accept letters of protection in lieu of payments on your account.** If there is no medical payment through your accident carrier and no medical insurance coverage, a letter of protection *may* be accepted in some circumstances. A letter of protection can only be accepted after reviewing and approving of the language in the LOP and a copy of your attorneys Professional Liability Policy.
- **We will bill your medical insurance carrier for an auto accident-related case ONLY after ALL MEDICAL PAYMENTS via your auto policy have been exhausted.** You must make arrangements with your medical insurance carrier to cover your care for the injury and show us proof of your medical insurance's confirmation to cover (proof of Subrogation). At that time, we will copy your medical insurance card and bill your medical insurance carrier for future treatments. (You will be responsible to pay all copayments, and or deductibles at time of service, and any treatment within the limits or outside the limits of your contract plan.) In the event that your insurance company denies our claims for treatment in any respect, you will be responsible for full payment of your account.

I have read and agree to PRAXIS Corporation's policy regarding payment responsibility.

I assign to PRAXIS Corporation my insurance benefits, settlement, or judgment proceeds, which are or shall become payable to me as a result of my injuries, in an amount equal to their fee for treating me, and grant PRAXIS an irrevocable lien on those benefits or proceeds for the payment of their fee.

I instruct and authorize _____ Insurance Company to issue a check to PRAXIS Corporation for charges I have incurred as a result of my treatment before anyone else, including me, is paid anything from such proceeds.

In reliance upon my assurance that this arrangement has been made and will be honored, PRAXIS Corporation has agreed to treat me according to the defined payment commitment. In consideration of that agreement which has enabled me to obtain treatment without financial hardship, I hereby make and declare the instructions herein contained to be irrevocable.

I am aware that I am responsible for paying PRAXIS Corporation the fee for treating me, and at any time, they can demand that I pay all or part of the balance of their fee. I also agree to pay all of PRAXIS Corporation's expenses to collect their fee, including a reasonable attorney fee.

I authorize this office to release any information pertinent to my case to any insurance company, adjustor, 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/sign my name on any and all checks for payment of my bill.

My signature below indicates that I have read, agreed to, and been provided a copy of the above agreement.

_____ _____
Patient Signature Date

_____
Patient Name (please print)

_____ _____
Witness Signature Date

9 YELLOW WOOD WAY, BECKLEY, WV 25801 • PHONE: 304.255.2376 • FAX: 304.255.7120