

Print Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**ASSIGNMENT OF BENEFITS**

I, \_\_\_\_\_, hereby authorize \_\_\_\_\_  
(Name of insured) (Name of insurance carrier)  
to pay to and mail directly to DR. MEL YOUNGS, D.C., P.A. the medical benefits otherwise payable to me or for my dependent for their services, but not to exceed the charges for those services. I hereby irrevocably assign to DR. MEL YOUNGS, D.C., P.A., any benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statutes for any services and charges provided by DR. MEL YOUNGS, D.C., P.A.

\_\_\_\_\_  
Patient or Guardian Signature Date

**IRREVOCABLE AGREEMENT FOR PAYMENT**

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care or treatment that any fees for professional services rendered to me will be immediately due and payable

I understand and agree that if charges are to be filed with an insurance carrier that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that DR. MEL YOUNGS, D.C., P.A. will prepare any necessary forms to assist me in making collection from my insurance carrier and that any amount authorized will be paid directly to DR. MEL YOUNGS, D.C., P.A. and will be credited to my account upon receipt. I understand that DR. MEL YOUNGS, D.C., P.A. is acting solely as an agent for me in filing to my insurance carrier for benefits assigned to me and authorize release of any information required to support my claim. However, DR. MEL YOUNGS, D.C., P.A. can assume no responsibility for guaranteeing payment of covered services. I understand that I am financially responsible for all charges whether or not paid by my insurance carrier as well as any attorney fees and costs incurred to collect for these services.

\_\_\_\_\_  
Patient or Guardian Signature Date

**CONSENT FOR TREATMENT**

I understand that as I am accepted as a patient of DR. MEL YOUNGS, D.C., P.A., I authorize DR. MEL and her staff to proceed with any treatment that may be medically necessary. Furthermore, any risks associated with Chiropractic treatment will be explained to me upon my request.

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Patient or Guardian Signature Date