



# Accident Relief Chiropractic

## Dr. William Ledbetter, III, B.S., D.C.

2376 Lavon Dr, Ste 134 | Garland, TX 75040  
214-703-9800 | Fax 214-703-8001

### PATIENT AGREEMENTS

Name: \_\_\_\_\_ Date of Injury: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN (last 4 digits): \_\_\_\_\_ Claim #: \_\_\_\_\_

THESE INSTRUCTIONS ARE IRREVOCABLE UNLESS ALL PARTIES AGREE IN WRITING TO REVOKE THE INSTRUCTIONS

PATIENT/PARENT/ or GUARDIAN AGREES: William H. Ledbetter, III, B.S., D.C. (hereinafter "Dr. Ledbetter") will provide chiropractic services for the injuries for which patient is currently seeking treatment. Patient promises to pay Dr. Ledbetter the usual and customary charges for treatment.

PATIENT/PARENT/ or GUARDIAN AGREES: I, \_\_\_\_\_ (or if a minor), on behalf of \_\_\_\_\_ hereby IRREVOCABLY ASSIGN to Dr. Ledbetter, in consideration of deferred billing and collection any claim or claims, chose in action, demand and cause of action, of whatsoever kind and nature, that have now or may have in the future for injures or damages as a result of an accident or incident occurring on or about

\_\_\_\_/\_\_\_\_/ **2020** \_\_\_\_\_, to the extent of charges for services provided or services to be provided by Dr. Ledbetter. If this assignment is made on behalf of a minor, the parent or guardian assigns only the cause of action such parent or guardian has for recovery of the minor's medical expenses incurred as a result of said accident or incident. In addition, Patient agrees to authorize Dr. Ledbetter or his staff to request Personal Injury Protection, Med Pay, or Uninsured/Underinsured Motorist Protection on my behalf from either my own auto insurance company or any other policy that may be available to me.

PATIENT/PARENT/ or GUARDIAN AGREES: I am responsible for all bills incurred at this office. Dr. Ledbetter shall not be liable for any costs and/ or expenses associated with any claims or litigation unless Dr. Ledbetter files that litigation. Dr. Ledbetter shall have no duty whatsoever to prosecute the claim or litigation. Nothing herein shall prevent patient from pursuing any claim or litigation which patient is otherwise entitled to pursue and which patient has not assigned to Dr. Ledbetter. Dr. Ledbetter may pursue any legal remedies as your assignee to collect its chiropractic bills. Patient may not settle any case involving recovery of Dr. Ledbetter's bills without the permission of Dr. Ledbetter. If a lawsuit is filed by either the patient or Dr. Ledbetter, arising from the said accident or incident, the non-filing party may intervene in the filed lawsuit and may not file a second lawsuit arising from the same accident or incident.

I, IRREVOCABLY instruct and direct any third party, whether or not I am represented by an attorney, making payment of damages incurred by patient as a result of said accident or incident, to make such payment by check or draft or other remittance jointly payable to Dr. Ledbetter and Patient/Parent/ or Guardian and/ or Attorney/.

I, IRREVOCABLY grant Dr. Ledbetter the power to endorse my name on any checks, drafts, or other negotiable instruments representing payment from any insurance company or any party for the chiropractic services provided to me by Dr. Ledbetter.

I AUTHORIZE and DIRECT any attorney retained by me at anytime to pay directly to Dr. Ledbetter all money for services provided to me, and to withhold the proceeds from my portion of any settlement, claim, judgment, or jury verdict.

I, UNDERSTAND and AGREE that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Dr. Ledbetter's staff will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Dr. Ledbetter, and will be credited to my account on receipt. However, I clearly understand and agree that all services, rendered me are charged directly to me and that I am personally responsible for payment. I also understand that is I suspend or terminate treatment any fees for professional services rendered me will be immediately due and payable.

\_\_\_\_\_  
Patient / Parent / or Guardian

\_\_\_\_\_  
Date