RECORDS RELEASE, ASSIGNMENT OF BENEFITS, LIMITED POWER OF ATTORNEY FOR THIS CASE, AND PAYMENT AGREEMENT

For value received, I hereby assign to Dr. Todd Stone and True Health Family Wellness Center, herein after referred to as Doctor, to the extent of my bill for health services, any and all claims which I may have:

(A) For benefits provided under any policy of insurance or other health care plan, including, but not limited to the following described policies.
(B) Against any other party whose negligence may have caused my injuries or who may be legally responsible for my injuries, illnesses, or health care costs.

I further hereby assign to Doctor a lien in the amount of my bill for health care services against the proceeds of any insurance policy, or health care plan and against any claim which I may have against any other party whose negligence may have caused my injuries, illnesses, or health care costs.

I hereby direct payment be made directly to Doctor, I hereby appoint Doctor as my true and lawful attorney, irrevocable, and with power of substitution for me and my name, to ask, demand, sue for, collect, endorse, sign and receive any such insurance or other benefit or claims against other parties for my injuries although Doctor shall be granted such powers contained herein, Doctor is not obligated or compelled to exercise such powers, but may do so at Doctors discretion. I agree to cooperate with Doctor in collecting any such amounts, including appearing in court if necessary. Doctor is further empowered to plan any and all information and documents pertaining to my policies including a copy of such policy and any information or supporting documentation concerning or touch upon the handling, calculation, processing, or payment of any claim.

In the event that I receive directly any check, draft, or other benefits subject to this assignment at a time when there is still a balance due to Doctor, I agree to deliver such check, draft or benefit to Doctor, immediately upon receipt, and the proceeds there of shall be applied to my bill.

I hereby authorize Doctor to release and to permit the examination or copying of any of my medical records, x-rays, laboratory reports, and the results of all tests of any type or character to such persons as Doctor deems appropriate.

In the event that provision of this agreement is determined to be invalid unenforceable, all other provisions of this agreement shall remain enforceable.

In witness where of, this agreement has been entered the day and year set forth below

Date Signature (Patient or Guardian if patient is a minor)