POWER OF ATTORNEY AND MEDICAL RELEASE

5290 Seminole Blvd. Suite A St. Petersburg, Fl. 33708

POWER OF ATTORNEY AND MEDICAL RELEASE

POWER OF ATTORNEY TO ENDORSE CHECKS AND/OR TO SIGN ANY PIECE OF PAPER WHICH WILL ENHANCE OR EXPEDITE PAYMENT TO PROVIDER FOR SERVICES RENDERED, INCLUDING BUT NOT LIMITED TO A RELEASE OF MEDICAL RECORDS AND ASSIGNMENT OF BENEFITS.AUTHORIZATION TO PAY.

Know by all those present that: The undersigned has made, constituted, and appointed, and by those present does hereby make, constitute and appoint **FLORIDA CHIROPRACTIC CLINICS, INC.**, and any of its duty authorized agents and employees as and to the undersigned's true and lawful attorney for and in the undersigned's name, place, and stead to endorse any and all checks, drafts, money orders which are made payable to the undersigned alone or to the undersigned and the said **FLORIDA CHIROPRACTIC CLINICS, INC.** which checks, drafts, money orders are made payable for services which have been made by **FLORIDA CHIROPRACTIC CLINICS, INC.** at the request or with the knowledge and approval of the undersigned and/or the maker of the check, draft, money order.

Furthermore, the undersigned allows **FLORIDA CHIROPRACTIC CLINICS, INC.**, or any of its agents to sign any paper that will be necessary to enhance, expedite, and/or allow payment to said provider. This may include affidavits of non-ownership of vehicles, insurance forms and other statements.

The undersigned by those present, does give and grant **FLORIDA CHIROPRACTIC CLINICS, INC.** as attorney, full power and authority to do and perform all and every act whatsoever requisite and necessary to be done in and about the premises as fully to all intents and purposes as the undersigned might or could do to personally present insofar as the endorsing and cashing of said checks are concerned as well as any other document.

MEDICAL RELEASE

A photocopy of this document shall be sufficient to authorize any person having records of medical treatment, services, and supplies pertaining to me to release true copies of same to **FLORIDA CHIROPRACTIC CLINICS, INC**. or any insurer providing coverage to me in connection with the processing of any claim for benefits made or by the assignee herein. A photocopy of this document shall be as binding as an original signature page.

The undersigned does hereby ratify and confirm any and all actions taken by the said attorney in accordance with this special power and which said attorney shall do or cause to be done by virtue of these presents.

ASSIGNMENT OF BENEFITS

I, ____ Hereby authorize ____

(Name of Insured/Patient) (Name of Insurance Carrier)

To make medical payments otherwise payable to me for services rendered by FLORIDA CHIROPRACTIC CLINICS, INC., but not to exceed the charges of those services, payable and mailed directly to:

FLORIDA CHIROPRACTIC CLINICS, INC.

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Furthermore, I hereby **IRREVOCABLY ASSIGN** to **FLORIDA CHIROPRACTIC CLINICS, INC.**, the rights and benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statutes for any service and or charges provided by **FLORIDA CHIROPRACTIC CLINICS, INC**.

IN WITNESS WHEREOF the undersigned have hereunto set their hands, this _________day of __________, 20___.

______________________________________ ______________________________________

PATIENT'S SIGNATURE PATIENT'S NAME (Please Print)