DAN DURRIEU, D.C.,'P.A.
AUTHORIZATION TO PAY DIRECTLY TO DOCTOR

Know by all those present that: The undersigned has made, constituted and appointed, and these presents does hereby make, constitute and appoint DAN DURRIEU, D.C., P.A., and any of it's duly authorized agents and employees as and to be the undersigned's true and lawful attorney for and in the undersigned's name, place and stead to endorse any and all checks, drafts or money orders which are made payable to the undersigned alone or to the undersigned and the said DAN DURRIEU, D.C., P.A.,which checks, drafts or money orders are made payable for services which have been made by DAN DURRIEU, D.C., P.A., at the request or with the knowledge and approval of the undersigned and/or the maker of the check, draft or money order.

Furthermore, the undersigned allows DAN DURRIEU, D.C., P.A., 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 these presents does give and ‘grant the said DAN DURRIEU, D.C., P.A., as attorney the lull power and authority to do and perform all and every act whatsoever requisite and necessary to be done in and about the promises 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, or supplies pertaining to me to release true copies of the same to DAN DURRIEU, D.C., P.A., or any insurer providing coverage to me in connection with the processing of any claim for benefits made by me or by the assignee herein. A photocopy of this document shall be as binding as an original signature page.

RELEASE OF INFORMATION

I hereby authorize this medical provider to : furnish my insurance company or companies and the patient's attorney with any and all information that may be contained in my medical records; to obtain coverage information telephonically from my insurer; to request a written non—redacted PIP payout sheet from the insurer; and to obtain copies of my medical records, including but not - limited to,‘documents, reports, scans, notes, opinions, X~rays and MRIs received from any other medical provider or any insurance company. The insurer is directed to keep the patient’s medical records private and confidential. The insurer is NOT authorized to provide these medical records to anyone, including but not limited to, third party vendors without the patient’s and the providers prior express written permission.

ASSIGNMENT OF BENEFITS

I, _____ hereby authorize_____
(Name Of insured/Patient} (Name of Insurance Carrier)
to make medical benefits payments otherwise payable to me for services rendered by DAN DURRIEU, D.C., P.A., but not to exceed the charges of those services, payable to and mailed directly to:

DAN DURRIEU, D.C., P.A.
5503 W. Waters Avenue, Suite 500
Tampa, Florida 33634

Furthermore, I hereby IRREVOCABLY ASSIGN to DAN DURRIEU, D.C., P.A., the rights and benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statutes for say service and or charges provided by DAN DURRIEU, D.C., P.A...

IN WITNESS WHEREOF the undersigned have hereunto set their hands, this _____ day of _____, _____

_____ _____

PATIENT’S SIGNATURE **PATIENT’S NAME (please print)**