



DIAMOND STATE CHIROPRACTIC, P.A.

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PAYMENT OF MEDICAL SERVICE COSTS

I, _____, hereby direct and authorize _____, Esq. and the law firm of _____, to pay all fees for medical services, including laboratory bills, medical reports fees, appearance fees, and other costs out of any recovery or settlement of my matter.

I understand that I am fully responsible for all medical bills, witness fees and administrative charges, or other costs incurred on my behalf whether or not there is a recovery through litigation or settlement or if the costs are not covered by insurance. Neither the attorney nor the law firm shall have any responsibility with regard to those costs and expenses.

I direct you, as my attorney, to contact **Diamond State Chiropractic, P.A.** at the time of settlement of my claim to notify them of the recovery and to obtain a statement of my accounts. In addition, I agree that no distribution of monies will be made to me until such time as my undisputed medical bills and costs have been paid.

I hereby agree that the above listed instructions are irrevocable and that a copy of this Agreement will be provided to the provider listed herein if required to receive continued treatment or other services.

A copy of this authorization shall have the same force and effect as the original.

The undersigned attorney for the above patient agrees to observe these terms and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect the interests of the service provider. If there is a dispute concerning these costs, the attorney agrees to hold adequate sums of monies in an escrow account until a resolution has been made between the medical service provider and my client.

Attorney Signature

Printed Name

Client Signature

Printed Name

Date: _____

Note: Please sign, date, and return to doctor's office at once. Keep a copy for your records.