# AUTHORIZATION
## INSURANCE BENEFITS AND ATTORNEY

**RE:**

To Whom It May Concern:

I hereby authorize and DIRECT you, my attorney, to PAY DIRECTLY TO **DR. CRIS E. LANGHEIER, P.O. Box 1287 Tarpon Springs, FL. 34688** such sums as may be due and owing this office for services rendered me, both by reason of accident or illness, and by reason of any other bills that are due to this office, and to withhold such sums from any disability, medical payments benefits, no-fault benefits, health and accident benefits, workers compensation benefits, or any other insurance benefits obligated to reimburse me or from any settlement, judgement or verdict on my behalf as may be necessary to adequately protect said office.

I, the undersigned, hereby agree that in the event of default in the payment of any amount due, and if this account is placed in the hands of an agency or attorney for collection or legal action, to pay any additional charges equal to the cost of collection, including agency and attorney fees and court costs incurred and permitted by laws governing these transactions.

I understand that I remain personally responsible for the total amounts due this office for their services. I further understand and agree that this Authorization does not constitute any consideration for the office to await payments and they may demand payments from me immediately upon rendering service at their option.

I authorize the office to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this Authorization.

I agree that the above-mentioned office be given Power of Attorney to endorse/sign my name on any and all checks/forms for payment of my doctor's bill.

**Patient's Signature:**_____ **Date:**_____

**Witness's Signature:**_____ **Date:**_____

THE UNDERSIGNED, BEING ATTORNEY OF RECORD FOR THE ABOVE PATIENT DOES HEREBY ACKNOWLEDGE RECEIPT OF THE ABOVE AUTHORIZATION, AND DOES AGREE TO HONOR THE SAME TO PROTECT ADEQUATELY SAID PROVIDER NAMED ABOVE.

**Attorney's Signature:**_____**Date:**_____

ATTORNEY: PLEASE DATE, SIGN AND RETURN ONE COPY TO PROVIDERS OFFICE.