HOWARD L. WEINSTEIN D.P.M.

TOTAL FAMILY FOOT CARE
3730 N. JOSEY LANE, SUITE 120
CARROLLTON, TEXAS 75007
(972) 492-4660

IN CONSIDERATION OF YOUR UNDERTAKING TO TREAT ME, I AGREE TO THE FOLLOWING:

YOU ARE AUTHORIZED TO RELEASE ANY INFORMATION YOU DEEM APPROPRIATE CONCERNING MY PHYSICAL CONDITION TO ANY INSURANCE COMPANY, ATTORNEY, MY EMPLOYER, OR ADJUSTER IN ORDER TO PROCESS ANY CLAIM FOR REIMBURSEMENT OF CHARGES INCURRED AT DR. HOWARD L. WEINSTEIN'S OFFICE.

I AUTHORIZE THE DIRECT PAYMENT TO YOU OF ANY SUM I NOW OR HEREAFTER OWE TO YOU BY MY ATTORNEY OUT OF THE PROCEEDS OF ANY SETTLEMENT OF MY CASE, AND BY ANY INSURANCE COMPANY OBLIGATED TO REIMBURSE ME FOR THE CHARGES FOR YOUR SERVICES OR OTHERWISE OBLIGATED TO MAKE PAYMENT TO YOU OR ME BASED IN WHOLE OR IN PART UPON THE CHARGES MADE FOR YOUR SERVICES.

IN THE EVENT ANY INSURANCE COMPANY OBLIGATED BY CONTRACTURAL AGREEMENT TO MAKE PAYMENT TO ME OR TO YOU FOR THE CHARGES MADE FOR YOUR SERVICES REFUSES TO MAKE SUCH PAYMENT UPON DEMAND BY YOU, I HEREBY ASSIGN AND TRANSFER TO YOU THE CAUSE OF ACTION THAT EXISTS IN MY FAVOR AGAINST ANY SUCH COMPANY, AND I AUTHORIZE YOU TO PROSECUTE SAID ACTION EITHER IN MY NAME OR YOUR NAME AS YOU SEE FIT AND FURTHER AUTHORIZE YOU TO COMPROMISE, SETTLE, OR OTHERWISE RESOLVE SAID CLAIM AS YOU SEE FIT. I UNDERSTANT THAT WHATEVER AMOUNTS YOU DO NOT COLLECT FROM INSURANCE PROCEEDS,(WHETHER IT BE ALL OR PART OF WHAT IS DUE),I PERSONALLY OWE YOU.

SIGNED_______________________________________

DATE____________________________