

ASSIGNMENT OF BENEFITS / POLICY RIGHTS

This Assignment of Benefits concerns the following:

PATIENT: _____
PROVIDER: New Tampa Chiropractic & Injury Center
PROVIDER ADDRESS: 2312 Crestover Lane, Suite 102 Wesley Chapel, FL 33544
DATE OF INCIDENT/ACCIDENT: ___/___/___
INSURANCE COMPANY NAME: _____
POLICY OWNER'S NAME: _____
POLICY OR CLAIM #: _____

I, _____, the undersigned patient, understand and agree that the above-referred Provider requires payment at the time services are rendered, in consideration of Provider agreeing to not require at the time services are rendered, hereby assign the rights and benefits of insurance of the applicable personal injury protection, medical payments, and/or other insurance which may be available to pay this Provider on my behalf to the said Provider for billings submitted by or on behalf of this Provider. This Assignment is for services and/or supplies rendered for treatment of personal injuries sustained in the automobile accident or incident on the above-referenced date to myself, the undersigned patient, who is covered by Personal Injury Protection (P.I.P) coverage or other insurance coverage under the above-named Policy Owner's name, in accordance with Florida Statute 627.7365. The undersigned is responsible for any applicable deductible or co-payment not covered by the said P.I.P. or other insurance. P.I.P. or other insurance contained herein, it is the intent of the parties hereto that this Assignment of Benefits shall only apply to goods, services and treatment rendered to the undersigned by this particular Provider/facility.

The assignment is intended to transfer all the patient's rights to collect benefits from the said insurance company, including, but not limited to, all rights to collect benefits directly from the insurance company for services that I have received and all rights to proceed against the insurance company which is obligated to provide benefits in any action including legal suit if for any reason the insurance company fails to make payments of benefits to which I am due. This Assignment further includes the right to collect payment for the reasonable costs connected with copying and mailing records to the insurer at the insurer's request and in accordance with Florida Statutes 627.736 (6). This Assignment also includes any right to recover attorney's fees and costs for such

action brought by attorney selected by them may be different than the attorney handling my personal injury/bodily injury claim or case. In the event of litigation or arbitration, I agree to cooperate with the said Provider and in any manner reasonably required. I understand that this cooperation may include giving sworn testimony at deposition, trial of the case, or any other proceeding that may be reasonably required, and I also agree to execute any releases, settlement papers, and settlement checks. I further agree not to compromise or extinguish the value of the Assignment by taking a position inconsistent with the said Provider's pursuit of payment.

This Assignment of Rights and Benefits is intended to become effective immediately and binding upon the said insurance carrier upon my execution. I hereby instruct the said insurance carrier that in the event the subject medical benefits are disputed for any reason, including medical reasonableness and/or necessity, that the amount of benefits claimed by the said Provider is to be set aside and not disbursed until the dispute is resolved. As part of this Assignment of Rights and Benefits, I further instruct the insurance carrier to notify the Provider immediately of any dispute as to payment so that it may exercise its legal rights. I have read and understood the information herein, and it is true to the best of my knowledge and belief.

PATIENT/GUARDIAN'S SIGNATURE:

PRINT PATIENT/GUARDIAN'S NAME:

DATE: ___/___/___

The undersigned, on behalf of the above referred Provider, hereby accepts assignment of the insurance rights and benefits for the goods, services and treatment rendered to above-referenced patient by the undersigned, and to be paid directly to the above-referred provider under the above-referred patient's Personal Injury Protection (P.I.P.) or other insurance coverage with above-referred insurance carrier and in accordance with Florida Statute 627.736 et Seq.

By: _____
(Authorized Agent/Representative)

Date: ___/___/___