

ASSIGNMENT OF INSURANCE BENEFITS AND RELEASE OF INFORMATION

INSURER PLEASE READ THE FOLLOWING, IN ITS ENTIRETY, UPON RECEIPT:

The undersigned patient/insured, _____ (print name of patient/insured or parent/guardian if patient is a minor), knowingly, voluntarily and intentionally **assigns the benefits** of insurance and any over due interest payments under the No-Fault Policy of Automobile Insurance, also known as Personal Injury Protection (P.I.P.), or Medical Payments policy of insurance with the responsible insurer to the above medical provider for any and all services rendered to the undersigned patient/insured. It is the intent of this medical provider to accept this assignment of benefits. The undersigned patient/insured directs the insurer to pay the medical provider directly (i.e. payments to be mailed and made payable to the medical provider only and not to me) for the services rendered. The insurer is further directed by the provider and the patient to not issue any checks or drafts in partial settlement of a claim that contain or are accompanied by language releasing the insurer or its insured from liability unless there has been a prior written settlement agreed to by the medical provider and the insurer by the insurer and deposited by the provider shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full.

The undersigned patient/insured agrees to pay any applicable deductible, co-payments, for services rendered after the policy of insurance exhausts, and for any other services unrelated to the automobile accident. The undersigned patient/insured agrees to comply with all of the terms and conditions of the policy of insurance at issue, including but not limited to, appearing for an independent medical examination and/or sworn statement at the request of the insurer. In the event the medical provider is required to file a lawsuit against the insurer for payment, the undersigned patient/insured agrees to cooperate with the medical provider's attorney and the insurer. In the event the subject medical benefits are disputed for any reason, including but not limited to, medical reasonableness and/or necessity, the undersigned patient/insured hereby instructs the insurer to set aside any amount disputed and not pay the disputed amount to anyone, including myself, or any entity until the dispute is resolved. Further, I hereby instruct the insurer to notify the provider immediately of any dispute as to payment so the medical provider can exercise its legal rights.

I understand this assignment will remain in full force and effect and will **NOT** be revoked unless the revocation is agreed to by both the medical provider **AND** the undersigned patient or the patient's attorney. This assignment applies to both past and future medical expenses. A photocopy of this assignment is to be considered as valid as an original.

Release of information: I hereby authorize this medical provider to furnish my insurance company or companies or their representative and/or my attorney with any and all information that may be contained in my medical records and to request a copy of my PIP payout sheet from the insurer.

Caution! Please read before signing. If you do not completely understand this document please ask us to explain it to you. If you sign below we will assume you understand and agree to the terms!

Patient's Signature _____ Date _____
(If patient is a minor, signature of parent/guardian)

Medical Provider's Signature _____ Date _____