ASSIGNMENT OF BENEFITS

We are a participating Out-of-Network provider.

Patient Name _____

Patient Address _____

Insurance Company _____

Claim Number _____ Date of Loss _____ / _____ / _____

1. I, the undersigned, hereafter referred to as "the patient," do hereby assign all of my rights and interests hereafter referred to as "the medical provider" to pursue and obtain payment from the above-mentioned insurance carrier. This assignment shall include but is not limited to, all rights available to me pursuant to the Personal Injury Protection Statutes of the State of New Jersey.

2. I assign, to the medical provider, all my rights and benefits under the insurance contract for payment for services rendered to me. However, upon consent of both parties, same shall be revocable.

3. I, the patient, do hereby understand and acknowledge that if I willfully refuse to comply with reasonable requests of the insurance carrier, payment of my medical bills may be denied and I will be held responsible for same.

4. I, the patient, authorize my bodily injury attorney to pay directly to the medical provider any monies due on my account, or, have same deducted from any settlement made on my behalf.

5. I, the patient, do hereby direct my health insurance carrier and/or other insurance carrier to issue payment on my behalf directly to the medical provider. The check should be made payable to the medical provider. Further, in the event that the health carrier and/or other insurance carrier fails to forward the check to the medical provider, I will endorse and sign the check to the medical provider within (5) days of receipt of same.

6. I, the patient, do hereby acknowledge that I will not file suit and/or arbitration for the payment of the above provider's medical bills unless I am requested to do so by the medical provider. I understand that the above referenced medical provider has an attorney and will collect payment on my behalf from the insurance provider.

7. I acknowledge and agree that, if I receive any check payments from my insurance carrier in connection with obtaining "out-of-network" services at the facility, I will endorse and assign the check to Atlantic Spine Center and immediately forward it to Atlantic Spine Center within five (5) days of receipt of the check. I understand that I am responsible for any amount not covered by insurance.

8. To prevent the insurance carrier and/or the vendor designated by the insurance carrier from refusing to accept my Assignment or submitting a challenge to my Assignment as being invalid, I execute this Special Power of Attorney and appoint and authorize the medical provider and counsel on behalf of the medical provider to file suit and/or arbitration directly against the insurance carrier in my name and/or allow the medical provider to amend the lawsuit and/or arbitration to include my name. I understand and acknowledge that the attorney chosen by the medical provider is to represent me individually on any claim for outstanding treatment with the medical provider in any appropriate forum. This Assignment serves as a limited retainer agreement between me and the attorney chosen by the medical provider for the sole purpose of representing me on a claim for outstanding treatment. I have been advised that if an arbitration and/or lawsuit is filed in my name individually, failure to include an outstanding medical provider's bills whom I have not executed an Assignment of Benefits with could make me liable for payment to that provider. In consideration, this medical provider has agreed to accept as payment in full, the amount awarded and/or settled and will not seek additional payment from other insurance carriers.

Patient Signature: _____ Date: _____ /_____ /_____

Patient's Initials: _____