



4406 S. Fla. Ave., Suite 16
Lakeland 33813
(863) 688-1800

Fax (863) 688-1824

820 Spring Lake Sq.
Winter Haven 33881
(863) 292-0921

**ASSIGNMENT OF BENEFITS,
LIENS AND DIRECT PAYMENT AUTHORIZATION**

INSURANCE COMPANY: _____

For and in consideration of the above-mentioned provider agreeing to pursue my insurance provider for payment of benefits due me and not requiring prepayment for services, I hereby irrevocably assign to the aforementioned medical provider (the 'Provider') any Personal Injury Protection benefits I may have in accordance with Florida Statute 627.736(5). This includes any benefits from my insurance company or any other entity that may be responsible for expenses incurred, and I authorize the 'Provider' to prosecute said action and collect legal expenses as they see fit. THIS DOCUMENT CONSTITUTES AN ASSIGNMENT OF BENEFITS. I hereby further give a lien to the 'Provider' against any and all insurance benefits named herein, and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by the 'Provider.' This is to act as an irrevocable assignment of my rights and benefits to the extent of the services provided. I agree to cooperate with the 'Provider' and any attorney that the 'Provider' chooses, and to do all things reasonable to effect payment of the bills by the insurance company to the 'Provider' including, but not limited to, disclosing patient's medical condition and treatment. This assignment concerns only the bills for the 'Provider' and those costs (including, but not limited to attorney's fees, court costs and interest) necessary in procuring payment from the above-named insurance company, etc. This assignment is not intended to assign any other causes of action that may belong to the undersigned patient. I agree to pay any applicable deductible or co-payment not covered by the PIP insurance coverage. I understand that this is a benefit and convenience to me in that the 'Provider' will pursue collection against the insurance company on my behalf. I hereby instruct and direct my insurance company to pay my benefits by check, made payable to and mailed to the 'Provider' at the address listed above. If my current policy prohibits direct payment to doctors, then I hereby instruct and direct my insurance company to make the check payable to me and mail it to the 'Provider' at the address listed above. If this 'Provider' is providing medical care related to an auto accident, 'Provider' is charging a reasonable fee for necessary care related to the accident, and these bills should be paid to the full extent of the benefits available under my policy of insurance. If any portion of any charge for these services is either reduced or denied in whole or in part, provider is to request that my insurance company place funds equal to the amount of the reduced or denied charges into escrow. My insurance company is to hold the escrowed funds for 'Provider' until such time as all escrowed funds are paid to 'Provider,' or 'Provider' instructs my insurance company that 'Provider' is no longer making any claim to the escrowed funds. Furthermore, I hereby give the 'Provider' limited power of attorney to endorse/sign my name on any and all checks for payment to the 'Provider.' This agreement is intended to serve as an assignment of the patient's rights and benefits under his/her aforementioned insurance policy in favor of the 'Provider'. If any language within this agreement has the effect of invalidating this assignment, that language shall be deemed void and the assignment shall remain in full force and effect. A photocopy of this assignment shall be considered as effective and valid as the original.

Patient Signature

Date

Print Patient Name

Witness Signature

Date