ASSIGNMENT OF BENEFITS

Patient Name: txt_Name|patientfullname

Patient Address: txt_Address|fullAddress

Date of Loss: txt_DOA|DOA Insurance Company: txt_InsCo|InsCo

Name of Policyholder: txt_Name|patientfullname

Policy Number: txt_PolicyNo|policy_no Claim Number: txt_ClaimNo|ClaimNumber

1. I, the undersigned, hereafter referred to as "the patient" do hereby assign all of my rights and interests to NJ Knee & Shoulder Care PC , 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 medicals 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 carrier.

7. In the event that the insurance carrier and/or the vendor designated by the insurance carrier does not accept my assignment, or my assignment is challenged for being invalid, I execute this limited/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 carrier in my name and/or allow the medical provider to amend the law suit and/or arbitration to include my name.

txt_Name|patientfullname

(Print Name of Patient)

(Signature of Patient)

Dated: _____ Witness: _____