# Accident & Injury Assignment of Benefits

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|---|---|---|
| Patient Name: | Date of Birth : | Date: |

## BENEFIT INFORMATION

☐ **Scenario #1: I have Auto Insurance, Health Insurance and an Attorney.**

- ☐ 1. To my knowledge, I still have Auto Insurance benefits available. I am electing to have my auto insurance billed until my benefits have exhausted. Once my benefits have exhausted, I am electing to have:
  - ☐ a. My Health Insurance billed. I understand I will be responsible for paying my deductible and/or copays in full at the time of service.
  - ☐ b. I am declining to have my Health Insurance billed and electing to have any and all balances that I incurred billed to my Attorney Lien.
- ☐ 2. I have been notified that my Auto Insurance benefits have been exhausted. I am electing to have:
  - ☐ a. My Health Insurance billed. I understand I will be responsible for paying my deductible and/or copays in full at the time of service.
  - ☐ b. I am declining to have my Health Insurance billed and electing to have any and all balances that I incurred billed to my Attorney Lien.

☐ **Scenario #2: I have Auto Insurance and an Attorney, but I do not have Health Insurance at this time.**

- ☐ 1. To my knowledge, I still have Auto Insurance benefits available. I am electing to have my Auto Insurance billed until my benefits have exhausted. Once my benefits have exhausted, I am electing to have any and all balances that I incurred billed to my Attorney Lien.
- ☐ 2. I have been notified that my Auto Insurance benefits have been exhausted. I am electing to have any and all balances that I incurred billed to my Attorney Lien.

☑ **Scenario #3: I do not have Auto Insurance but I was injured in a Motor Vehicle Accident.**

- ☑ 1. Please bill my Health Insurance. I understand I will be responsible for paying my deductible and/or copays in full at the time of service.
- ☐ 2. Please bill my Attorney Lien.
- ☐ 3. Please bill my Health Insurance. Anything that is not covered by my Health Insurance, please bill to my Attorney Lien. I understand I will be responsible for paying my deductible and/or copays in full at the time of service.

## POLICY INFORMATION

**Auto Insurance:**

tes

Name of Insurance Company

44

Policy Number

Claim Number

44.00

Deductible

44.00

Copay

**Policy Holder Information (If policy holder is someone other than patient)**

44

Name

1

Relationship to Patient

04/13/2017

Date of Birth

444

SSN

(444) 44

Phone

444,444,44,1,44

Address

Employer

(444) 44

Employer Phone

# Accident & Injury Assignment of Benefits Continued

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Patient Name:

01/17/1889

Date of Birth :

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Date:

## POLICY INFORMATION CONTINUED

**Primary Medical Insurance:**

tes

Name of Insurance Company

| | |
|---|---|
| 44 | 44 |
| Policy Number | Group Number |
| 44.00 | 44.00 |
| Deductible | Copay |

**Policy Holder Information (If policy holder is someone other than patient.)**

| | | |
|---|---|---|
| 44 | 1 | |
| Name | Relationship to Patient | |
| 04/13/2017 | 444 | (444) 44 |
| Date of Birth | SSN | Phone |

444,444,44,44,1,44

Address

**Secondary Medical Insurance:**

tes

Name of Insurance Company

| | |
|---|---|
| 44 | 44 |
| Policy Number | Group Number |
| 44.00 | 44.00 |
| Deductible | Copay |

**Policy Holder Information (If policy holder is someone other than patient.)**

| | | |
|---|---|---|
| | 1 | |
| Name | Relationship to Patient | |
| 04/13/2017 | 444 | (444) 44 |
| Date of Birth | SSN | Phone |

444,44,1,44,

Address

**Attorney Information:**

Attorney Name

Claim Number

Attorney Phone

,,,,

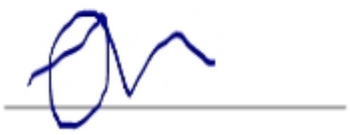
Attorney Address

I hereby instruct and direct the above insurance company(s) to pay by check made out to: Advanced Physical Therapy of Central Florida (P: 352-693-3378) and mailed to 303 SE 17th Street #309-229, Ocala, Florida 34471. If my/this current policy prohibits direct payment to doctor/therapist, I hereby also instruct and direct you to make out the check to me and mail it to the above address for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered.

## This is a direct assignment of my rights and benefits under this policy.

This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. Please check each box and sign at the bottom.

- ☑ A photocopy of this Assignment shall be considered as effective and valid as the original.
- ☑ I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment of benefits.
- ☑ I authorize the use of this signature on all insurance submissions.
- ☑ I authorize the "Healthcare Provider" named above to deposit checks made in my name.
- ☑ I authorize the "Healthcare Provider" named above to initiate a complaint to the Insurance Commissioner for any reason on my behalf.
- ☑ I understand that I am financially responsible for all charges whether or not paid by insurance.



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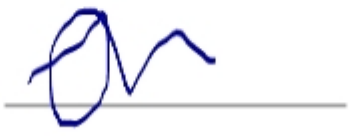
**Signature of Policyholder**



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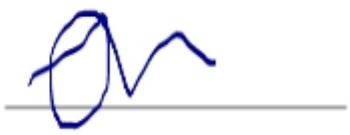
**Signature of Claimant**
(If other than Policyholder)



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**Signature of Witness**