ASSIGNMENT OF BENEFITS/ POLICY RIGHTS

This Assignment of Benefits Concerns the following:

PATIENT: _____

PROVIDER: DR CRIS E. LANGHEIER

PROVIDER ADDRESS: _____

_____

DATE OF INCIDENT/ACCIDENT: _____

INSURANCE COMPANY NAME: _____

POLICY OWNERS'S NAME: _____

POLICY OR CLAIM NUMBER: _____

PATIENT: I, the undersigned patient, understand and agree that the above-referred Provider requires payment at the time services are rendered, in consideration of provider not requiring payment at the time services are rendered, hereby assign the rights and benefits of insurance of the applicable personal injury protection, medical payments, and/ or other insurance which may be available to pay Provider on my behalf to the said Provider. This assignment is for services and/ or supplies rendered for treatment of personal injuries sustained in the automobile accident or incident on the above-referenced date to myself, the undersigned patient, who is covered by Personal Injury Protection (PIP) coverage or other insurance coverage under the above-named Policy Owner's name, in accordance with Florida Statutes 627.736(5). The undersigned is responsible for any applicable deductible or co-payment not covered by the P.I.P or other insurance coverage. PIP or other insurance policy rights, which I am assigning hereby, are to be covered through a policy of insurance with the company commonly known as the above-referred insurance company, policy or claim number. In the event an error has been made in naming the appropriate insurance company, policy, or claim number, I agree to execute any further or additional documents to remedy such error. It is my intent to assign benefits and/or policy rights from any applicable PIP, medical payments, and/or other insurance for which benefits may be paid to said Provider on my behalf as a result of injuries sustained by me in the above-referred incident/accident.

This assignment is intended to transfer all of the patient's right to collect benefits from said insurance company, including. But not limited to, all rights to collect benefits directly from the insurance company for services that I have received and all rights to proceed against the insurance company which is obligated to provide benefits in any action including legal suit if for any reason the insurance company fails to make payments of benefits to which I am due. This Assignment further include the right to collect payments for the reasonable costs connected with the copying and mailing records to the insurer's request and in accordance with Florida Statues 627.736 (6). This assignment also includes any right to recover attorney's fees and costs for such action brought by the Provider as Patient's assignee. I agree that the said provider may select any attorney it wishes and understand and agree that the attorney selected by them may be different that the attorney handling my personal injury/ bodily injury claim or case. In the event of litigation or arbitration, I agree to cooperate with the said Provider and in any manner reasonably required. I understand that this cooperation may include giving sworn testimony at deposition, trial of case, or any other proceeding that may be reasonably required, and I also agree to execute any releases, settlement papers, and settlement checks. I further agree not to compromise or extinguish the value of this Assignment by taking a position inconsistent with the said Provider's pursuit of payment.

This Assignment of Rights and Benefits is intended to become effective immediately and binding upon the said insurance carrier upon my execution. I hereby instruct the said insurance carrier that in the event the subject medical benefits are disputed for any reason, including medical reasonableness and/ or necessity, that the amount of benefits claimed by the said Provider is to be set aside and not disbursed until the dispute is resolved. As part of this Assignment of Rights and Benefits, I further instruct the insurance carrier to notify the provider immediately of any dispute as to payment so that it may exercise its legal rights. I have read the information herein and it is true to the best of my knowledge and belief.

_____	_____	_____
Patient/ Guardian Signature	Print Patient/ Guardian's Name	Date

Provider: The undersigned, on behalf of the above-referred Provider, hereby accepts assignment of the insurance rights and benefits for the services rendered to above-referenced patient, and to be paid directly to the above-referred Provider under the above-referred patient's Personal Injury Protection (P.I.P) or other insurance coverage with above-referred insurance carrier and in accordance with Florida Statue 627.736 et Seq.

By: _____ Date: _____

Authorized Agent/ Representative

Dr. Cris E. Langheier