ALLEGIANCE ORTHOPEDIC AND SPINE INSTITUTE, PLLC

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ASSIGNMENT OF INSURANCE BENEFITS, POWER OF ATTORNEY AND RELEASE OF INFORMATION

The undersigned patient/insured _____ (and name of patient or parent/guardian if patient is a minor), knowingly, and voluntarily and intentionally assigns the ***benefits*** if insurance and any overdue interest payments under the No-Fault Policy if Automobile Insurance, also known as personal injury protection (P.I.P.), or medical payments policy of insurance from my automobile insurer or the responsible insurer to the above described medical provider for any and all services rendered to the undersigned patient insured. It is the intent of this medical provider to accept this assignment of benefits. The undersigned patients/insured directs the insurer to pay the medical provider directly (i.e. payments to be mailed and made payable to the medical provider only and not to me) for the services rendered. The insurer is further directed by the provider and the patient to not issue any checks or drafts in partial settlement of a claim that contain or are accompanied by language releasing the insurer or its insured from liability unless there has been a prior written settlement agreed to by the medical provider and to the insurer as to the amount payable under the insurance policy or contract. The provider hereby objects to any reductions or partial payments made at the discretion of the insurer. Any partial or reduced payment issued by the insurer and deposited by the provider shall be done so under pretest and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the provider to accept a reduced amount in full. The insurer is hereby placed on notice that this provider reserves the right to seek the full amount of the bills submitted. In the event the subject medical benefits are disputed for any reason, including but not limited to, medical reasonableness and/or necessity, the undersigned patient/insured hereby instructs the insurer to set aside any amount disputed (i.e. to escrow the money) and not pay the disputed amount to anyone, including myself, or any entity until the dispute is resolved. Any partial payment, regardless of the accompanied language, will be deemed a partial payment and the insurer will be making a payment at its own risk unless there is a prior written statement agreed to by this provider. I hereby instruct the insurer to notify the above provider immediately of any dispute.

The undersigned patient/insured agrees to pay and deductible, co-payments, for services rendered after the policy of insurance exhausts, and for any other services unrelated to the automobile accident. In the event the medical provider is required to file a lawsuit against the insurer for payment, the undersigned patient/insured agrees to cooperate with the medical provider's attorney and the insurer. I understand this agreement will remain in full force and effect and will **NOT** be revoked unless the revocation is agreed to by both the medical provider **AND** the undersigned patient or the patient's attorney. This assignment applies to both past and future medical expenditures. A photocopy of this assignment is to be considered as valid as an original.

The parties to this assignment of benefits stipulate and agree, and do hereby make it perfectly clear, that under no circumstances is the assignee being delegated by me, the patient assignor, any duties whatsoever, whether: (a) under any insurance policy/policies or benefits to which I may be a party or beneficiary (including but not limited to personal injury protection("P.I.P."), medical payments, health, indemnity, liability, subrogation, umbrella, excess, uninsured/underinsured motorist, or other polices or benefits); or (b) pursuant to any law, rule, or regulation that may address assignment of benefits in medical care circumstances; or (c) under any other circumstances whatsoever. The assignee is not agreeing to assume or in fact assuming any duties or obligations that I, the patient, ever had, now have or may have, or May hereafter acquire under any circumstances policy, law, rule, or regulation. I, the patient, am the assignor under the assignment of benefits, and I am not, in any way or in any degree, delegating any duties or obligations to the assignee. The assignee under this assignment of benefits is merely being assigned the right to bill for and receive payment that I would otherwise be entitled to

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Bill for and/or receive myself—this is an assignment by me of the right to bill and receive, not the creation of any duty or obligation on the part of the assignee to do anything whatsoever. There are no third party beneficiaries to this assignment of benefits/agreement, and no one else, including but not limited to any insurance company, has any right to attempt to require anything from the assignee by reason, in whole or part, of this assignment off benefits. Further, I, the patient assignor, agree to preform, timely and in full, any and all duties and obligation that I may have under any insurance policy (whether as insured or a beneficiary thereof, or under any law, rule, or regulation), that are or may be conditioned to my right to receive (directly or indirectly) benefits, including but not limited to payment, from any insurance carrier, irrespective of whether I have assigned any or all such benefits to assignee. If I, the patient assignor, should fail to timely and fully preform any and all such duties and obligations, or otherwise cause, in whole or part, the assignee not to receive timely and fully receipt of all benefits I have assigned, including but not limited to payment that I would otherwise been entitled to, then assignee shall be entitled to hold me personally and fully liable and responsible for all sums due to assignee, whether the same as or in excess of those that would otherwise have been due to assignee by reason of my assignment of benefits to the assignee. I, patient assignor, do hereby further assign to the assignee, medical provider or facility, as the case may be, my right to sue any insurance company/insurer that may be obligated to provide benefits to me, as an insured or as a beneficiary of such insurance policy or policies, for all or any part of the charges incurred by me (patient/assignor) from the assignee/medical provider/facility for said assignee's provision of any care treatment, services, or supply whatsoever, plus interest, attorney fees, cost, and expenses, and to collect, by judgment or otherwise, all of same from any/all said insurer/insurance company/companies. This assignment of my right to sue shall include, but not limited to, suing for PIP benefits/payments. All duties or obligations of the insured, patient, or a person making a claim for benefits under any insurance policy by which I am an insured or a beneficiary, are being retained by me as my duties and obligations, and are not being delegated (or assigned) to assignee. The assignee is not a party to any insurance policy to which I am a part, and I am not, by this document or otherwise, making or attempting to make the assignee a party to any such insurance policy.

Power of attorney I also agree the above provider is hereby given the power of attorney to sign my name on any checks for payment for services provided by the above provider.

Release if information I hereby authorize this medical provider or their representative to furnish my insurance company or companies and my attorney with any and all information that may be contained in my medical records, to request a copy of my PIP and/or Med-Pay payout sheet from the insurer and obtain any insurance coverage information in my file. I also hereby authorize this medical provider to obtain copies of my medical records, including but not limited to, documents, reports, scams, notes, opinions, x-rays, and MRI'S, from any other medical provider or any insurance company.

Caution! Please read before signing. If you do not completely understand this document, please ask us to explain it to you. If you sign below, we will assume you understand and agree to the terms.

Patient's Signature _____Date: _____

Authorized Signature: _____Date: _____

**Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information may be guilty of a felony of the third degree.