INNOVATIVE
SPINE CARE

10903 Sheldon Road • Tampa, FL 33626
Phone: 813-920-3022 • Fax 813-920-3002

www.GotSpinePain.com

Assignment of Benefits (1/2)

Patient: _____ Date of Loss: _____

Insurance Carrier: _____ Claim Number: _____

Policy Owners' Name: _____ Policy Number: _____

For and in consideration of (PATIENT'S NAME): _____ agreeing to pursue the responsible automobile insurance carrier for payment of benefits due and not requiring prepayment of services, I hereby irrevocably assign ALL rights and benefits to INNOVATIVE SPINE CARE for Personal Injury Protection, Medical Payment Coverage, and other benefits which I may have in accordance with Florida statute 627.736. This includes any benefits from my insurance company and any other entity which may be responsible for medical expenses incurred. I further authorize INNOVATIVE SPINE CARE to collect payments& prosecute any necessity actions to collect payment for services as they see fit and allowable by law and contract. THIS DOCUMENT CONSTITUTES AN ABSOLUTE ASSIGNMENT OF RIGHTS AND BENEFITS AS CONTEMPLATED IN PROGRESSIVE AMERICAN INS. CO. V. STAND-UP MRI OF ORLANDO, 990 SO.2D3 (FLA. 5TH DCA 2008).

I hereby further give a lien to INNOVATIVE SPINE CARE against any 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 injuries or illness for which I have been treated by INNOVATIVE SPINE CARE as a result of the above stated loss date. This document acts as an irrevocable and absolute assignment of all my rights and benefits under all policies of insurance for which I am entitled to coverage thereupon. I agree to cooperate with all employees of INNOVATIVE SPINE CARE and their attorney's (at their choosing), and to do all things reasonable to effect payment of the bills by the insurance company or other entity to INNOVATIVE SPINE CARE including but limited to: disclosing my medical condition, being available for factual discovery, or any other means of cooperation.

INNOVATIVE SPINE CARE hereby objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protest, at the risk of the insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement, or agreed by the provider to accept a reduced amount as payment in full.

This assignment concerns amounts due INNOVATIVE SPINE CARE and those costs including but limited to: attorney fees, court costs, special report or narrative fees, other costs, and interest necessary to procuring payment from the above-named insurance company and/or other entities. 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/s, co-insurance/s, co-payment/s, or any not covered items by any policy of the insurance cited above. I understand that as a benefit and convenience to me, INNOVATIVE SPINE CARE will bill and pursue collection against the insurance company or other responsible party on my behalf. I hereby instruct and direct my insurance company to pay benefits directly to INNOVATIVE SPINE CARE at the address provided on the bill.

Assignment of Benefits (2/2)

INNOVATIVE SPINE CARE's medical care is being provided for a reasonable fee for treatment causally related to the above loss date and is medically necessary. I instruct my insurance carrier or other responsible entity to pay these bills to the full extent of my available benefits under the insurance policy and Florida law. I hereby give INNOVATIVE SPINE CARE limited Power of Attorney to endorse and sign my name on any draft for payment to INNOVATIVE SPINE CARE.

This agreement is intended to serve as an absolute assignment of rights and benefits under my policy of insurance in favor of INNOVATIVE SPINE CARE. If any language within this agreement has the effect of invalidating this agreement, that language shall be deemed void and the remainder of the assignment shall maintain full force and effect. A photocopy of this agreement shall be considered as effective and valid as the original.

As INNOVATIVE SPINE CARE stands in my shoes by virtue of this assignment, the following constitutes rights now owned by INNOVATIVE SPINE CARE, as I have directed herein, and INNOVATIVE SPINE CARE hereby demands, including but limited to:

A. Providing a copy of any applicable insurance policy, declaration page, all applicable endorsements.
B. Transcripts and/or copies or recorded statements, examinations under oath, affidavits of the claimant, affidavits of any provider who treated me, or other sworn statements pursuant to Addison v. Geico General Ins. Co., 17 Fla. L. Weekly Supp. 272a (Hills. Cty. Ct. 2010).
C. Copies of independent or compulsory evaluation, including peer reports or other reports pursuant to 627.736(7) of me.
D. Any police or accident report my insurance company may have for the above listed date of loss
E. A listing of all PIP benefits paid to date on my behalf of AND to me which shall include claims were received, the amount of the claim before reductions or repricing, payment amount or denial of each claim, the amount of the deductible and the claims applied thereto, and whether benefits have been exhausted and the amount of PIP benefits available, commonly known as a "PIP LOG" or "PIP PAYOUT LOG". This is specific to include ALL medical, disability, and death claims under Personal Injury Protection, Medical Payment Coverage, and other benefits which I may have in accordance with Florida statute 627.736 and the names of each biller and payee.
F. Providing notice or any request under any cooperation clause of the policy, including but not limited to: requests for EUO or IME attendance to our office as WE STAND IN THE SHOES OF THE INSURED. Any EUO or IME taken without providing us reasonable notice and allowing counsel of our choosing to attend is INVALID.
G. All notices and requests for information under Florida Statute 627.736(6)(b) are to be directed to our attorney, PHILLIP A. FRIEDMAN, ESQ. , FL LEGAL GROUP, 501 E Kennedy Blvd., Ste 810, Tampa, FL. 33602.

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

IF PATIENT IS INCAPACITATED OR UNDER THE AGE OF 18, PLEASE INDICATE THE PATIENT NAME, GUARDIAN NAME, RELATION TO PATIENT, AND OBATAIN GUARDIAN SIGNATURE.