

**Assignment of Benefits and Directions to Pay Benefits Owed**

I, the undersigned insured or beneficiary of an insurance policy, irrevocably assign to **8 FLAGS CHIROPRACTIC, INC.**, hereafter "**Provider**", whatever rights I have under any policy of insurance and under Florida law, including, without limitation, any and all claims for attorney's fees, costs, interest and/or damages pursuant to Florida Statute 624.155. This Assignment of Benefits (AOB) includes an assignment of any potential claim for common law or statutory bad faith. If the Insurer disputes the validity of this AOB, then the insurer is instructed to notify the provider in writing within 10 days of receipt of this document. Failure to do so shall result in the provider relying on this AOB for direct payment and could constitute a waiver by the insurer to contest the validity of this document. I do hereby confirm that this AOB is irrevocable and instruct any insurance company or other collateral source for which I am entitled to benefits to pay for monies owed as a result of medical services rendered by **Provider** to promptly make payment in the name of and directly to **Provider** or its chosen billing service.

Pursuant to this AOB, **Provider** is authorized to file suit on my behalf against any insurance company that reduces or denies benefits for medical services rendered to me and to collect any damages awarded or settlement monies for services rendered, plus interest, costs, reasonable attorney's fees and a contingency fee multiplier. I understand that in any such lawsuit, my name or other identifying information will need to be included in and/or portions of my medical file attached to pleadings and/or formal discovery. I waive any confidentiality of my records and/or information but only to the extent necessary to prosecute a claim for unpaid or owed medical expenses against the insurance company or any other responsible party.

I acknowledge that **Provider** objects to any reductions or partial payments by the Insurer. Any partial or reduced payment, regardless of the accompanying language, issued by the Insurer and deposited by **Provider** shall be done under protest, at the risk of the insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full. **Provider** reserves the right to seek the full amount of the bill submitted from the insurance company(ies) or me. Accordingly, the insurer is hereby instructed to set aside (escrow) any and all reduced or denied benefit payments for medical services rendered by this provider and not pay the disputed amount to anyone until the dispute is resolved.

I further instruct my insurance company to cooperate with the above-captioned **Provider** in resolving all medical billing disputes. Cooperation includes, but is not limited to, providing any and all declaration pages, PIP logs, payout ledgers, explanations of benefits, copies of checks, and any and all other documents or information to **Provider** or its attorneys, employees or other representatives acting on behalf of **Provider**. If the insurer schedules a defense examination, examination under oath (EUO) or Independent Medical Examination (IME) of the patient, the insurer is hereby instructed to send a copy of said notification to this provider and the provider's attorneys. The provider and/or the provider's attorneys are authorized to appear at any patient EUO or IME set by the insurer. **THIS ASSIGNMENT OF BENEFITS DOES NOT ASSIGN ANY RIGHTS OR OBLIGATIONS UNDER THE POLICY OF INSURANCE, TO SUBMIT TO AN EUO OR RECORDED STATEMENT.** I further direct and authorize you to speak to an attorney, employee or any other representative of **Provider** or anyone acting on their behalf over the phone and provide them with any and all information you may have or documentation not previously listed above that they may request.

I, as the patient, agree to remain personally liable for the amounts billed by **Provider** regardless of the amount paid by the insurance company, unless ordered by a court of law. I fully understand that said health care services were provided to me in consideration for an unconditional promise to pay and for me providing these instructions to my insurance company. I, as the patient, further agree to be liable for reasonable attorney's fees and costs incurred in collecting any delinquent accounts or unpaid balances. By executing this document, I am placing my insurance company(ies) on notice that the claims for medical treatment rendered by **Provider** are related to my accident (or my covered conditions) and should be paid directly to **Provider** pursuant to this assignment of benefits and Florida law. Any delay in paying benefits owed under the insurance policy could adversely affect me.

BY EXECUTING THIS DOCUMENT, I AM PLACING MY INSURANCE COMPANY ON NOTICE THAT THIS IS A DIRECT ASSIGNMENT OF BENEFITS PURSUANT TO FLORIDA LAW. AS THE INSURED OR BENEFICIARY OF SAID INSURANCE POLICY, I AM IRREVOCABLY ASSIGNING WHATEVER RIGHTS I HAVE UNDER MY POLICY OF INSURANCE (LESS THE DUTY TO ATTEND AN EUO) AND UNDER FLORIDA LAW TO THIS HEALTH CARE PROVIDER. A photocopy of this assignment shall be considered as effective and valid as the original.

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Patient's Name/DOB

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Signature of Policy holder or Claimant/Date

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Name of Policy holder or Claimant

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Acceptance of **Provider**/Date