1793 W. Hillsborough Ave.
Tampa, FL 33603
Ph: 813-876-7373 • Fax: 813-876-7375

Patient: ____

Insurance Company: ______________________________

Claim #: _______________________________________

ASSIGNMENT OF BENEFITS AND INSTRUCTIONS FOR DIRECT PAYMENT TO PROVIDER

Pursuant to Florida Statute 627.736(5) the undersigned patient hereby **assigns** the benefits of insurance and any and all causes of action available under the policy of automobile insurance to **A+ Rehab Medical Center** to receive payment for services rendered to the undersigned and which are payable under Personal Injury Protection Coverage (PIP) and/or Medical Payments Coverage of the Insurance policy.

As prescribed by Florida Statute 627.730-627.741, all payments shall be overdue if not paid within 30 days after the insurer is furnished written notice of the fact of a covered loss and the amount of same. All overdue payments shall bear simple interest at the rate prescribed by statute.

By virtue of this assignment, the undersigned directs that all payments should be issued solely in the provider's name and forwarded directly to the office of **A+ Rehab Medical Center.**

In the event of a dispute involving payment of my physician's bill, in order to maximize the benefits available under my policy coverage, and to continue to receive necessary treatment while the dispute is being resolved, I request the company adhere to the following. Assuming there is coverage remaining at the time the Company receives the physician's bill, if the company fails to pay **A+ Rehab Medical Center** the full amount of the treatment bill submitted, to avoid the exhaustion of coverage while this provider pursues its rights under this Assignment**, I authorize and direct the Insurance Company, to set aside and place in escrow, an amount equal to the full amount of any such reduction/non-payment and to hold that amount in escrow until the dispute is resolved in the appropriate forum.**

It is acknowledged and agreed that in the event I have a wage loss claim, that **A+ Rehab Medical Center** assignment takes precedence.

Further, I authorize and direct my Insurance Company to provide **A+ Rehab Medical Center** and/or their Attorney, a complete, unaltered, and updated copy of the PIP and Medical Payments coverage payment records as needed, to include and provide all payments, dates received and amounts paid.

It is agreed that this assignment will remain in full force until 48 hours after **A+ Rehab Medical Center** receives written notice that it is being revoked, it is specifically agreed that any such revocation of this Assignment will not apply to any treatment or associated expenses incurred on or before appropriate notice of revocation is received by **A+ Rehab Medical Center.**

To the extent that any provision of this assignment is found to be unenforceable, all remaining provisions shall remain in full force and effect. A photocopy of this Assignment shall be considered as effective as the original.

Patient's Signature __________________________________ Date ___________________