Team Lopez Chiropractic

ASSIGNMENT OF BENEFITS
LIENS AND DIRECT PAYMENT AUTHORIZATION

MEDICAL PROVIDER: Team Lopez Chiropractic
15497 Stoneybrook West Parkway
Suite 180
Winter Garden, Florida 34787

INSURANCE COMPANY: _____

For and in consideration of the above-mentioned provider agreeing to pursue my insurance provider for payment of benefits due me and not requiring prepayment for services, I hereby irrevocably assign to the aforementioned medical provider (the "provider") any Personal Injury Protection benefits I may have in accordance with Florida Statute 627.736 (5). This includes any benefits from my insurance company or any other entity that may be responsible for expenses incurred, and I authorize the Provider to prosecute said action and collect legal expenses as they see fit. THIS DOCUMENT CONSTITUITES AN ASSIGNMENT OF BENEFITS. I hereby further give a lien to the provider against any and 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 the injuries or illness for which I have been treated by the provider. This is to act as an irrevocable assignment of my rights and benefits to the extent of the services provided. I agree to cooperate with the provider and any attorney that the provider chooses, and to do all things reasonable to effect payment of the bills by the insurance company to the provider including, but not limited to, disclosing patient's medical condition and treatment. This assignment concerns only the bills of the provider and those costs (including, but not limited to, attorney's fees, courts costs and interests) necessary in procuring payment from the above-named insurance company, etc. 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 or co-payment not covered by the PIP insurance coverage. I understand that this is a benefit and convenience to me in that the Provider will pursue collection against the insurance company on my behalf. I hereby instruct and direct my insurance company to pay my benefits by check, made payable to and mailed to the provider at the address listed above. If my current policy prohibits direct payment to doctors, then I hereby instruct and direct my insurance company to make the check payable to me and mail it to the Provider at the address listed above. Furthermore, I hereby give the Provider limited power of attorney to endorse/sign my name on any and all checks for payment to the Provider. This agreement is intended to serve as an assignment of the patient's rights and benefits under his/her aforementioned insurance policy in favor of the Provider. If any language within this agreement has the effect of invalidating this assignment, that language shall be deemed void and the assignment shall remain in full force and effect. A photocopy of this assignment shall be considered as effective and valid as the original.

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date