

Genesis Medical Clinic
11351 N 56th Street
Temple Terrace, FL 33617
Tel 813-549-7465 Fax 813-549-7399

Patient Name: _____
Address: _____
City: _____ Stet: _____ Zip: _____
DOI: _____ Claim # _____

ASSIGNMENT OF BENEFITS/POLICY RIGHTS/DIRECT PAYMENT AUTHORIZATION

I hereby assign from any and all automobile policies which provide medical benefits or no-fault benefits, all rights, title and interest to Superior Medical Clinic, LLC ("Assignee") for payment for services rendered unto me both by reason of accident or illness. In the event my insurance company fails to pay Assignee the full amount owing to Assignee after proper statutory notice, I hereby also assign by this instrument, all rights and causes of action in tort, in contract and the laws of Florida, against the personal injury protection carrier for the above named insured/patient for it's failure to pay for services rendered unto me by assignee in relation to any accident or illness. This assignment may only be rescinded/reassigned by the mutual consent of the patient/insured/assignor and health care provider/assignee.

RESERVATION OF BENEFITS

Please be advised that I am hereby placing you on notice pursuant to Florida case law that should you deny, reduce or fail to pay either a part or an entire bill, which was submitted on my behalf from this healthcare provider. I am requesting you reserve, or hold aside, that same amount until the dispute is resolved. Additionally, should the remaining amount of any benefits approach an amount where there would be insufficient funds to pay the amount you reduced, denied or failed to pay, or if my benefits should become exhausted, please notify me and this health care provider of this fact immediately.

DIRECTION OF PAYMENT/RELEASE OF INFORMATION

I hereby authorize any insurance company or attorney to pay direct to Assignee the amount of this and/or any future bills for services rendered unto me. I also agree to pay in a current manner any difference between the total charges and the amount paid by the insurance company directly to the Assignee. I hereby authorize Assignee to release any information requested that is pertinent to my case to any insurance company or attorney involved in this case. Pursuant to FS 627.4137, I hereby request a copy of the PIP payment log and any available policy of Insurance or declaration sheet, to be provided by the insurance company to the Assignee. I hereby authorize Assignee permission to request and receive a current copy of my PIP payment log periodically as they deem necessary. A photocopy of this assignment shall be considered as valid and effective as the original.

Patient's signature or patient/guardian

Date