Urmos Chiropractic Health Center

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ASSIGNMENT OF INSURANCE BENEFITS, RELEASE & DEMAND

INSURER AND PATIENT, PLEASE READ THE FOLLOWING IN ITS ENTIRETY

- I, the undersigned patient/insured knowingly, voluntarily and intentionally assign the rights and benefits of my Automobile Insurance, also known as Personal Injury Protection (PIP), and Medical Payments policy of insurance to the above healthcare provider. I understand that it is the intention of the provider to accept this assignment of benefits in lieu of demanding payment at the time services are rendered and that this document will allow the provider to file suit against the insurance company for payment and insurance benefits. This assignment of benefits includes overdue interest payments and any potential claim for common law or statutory bad faith. If the insurer disputes the validity of this assignment of benefits, the insurer is instructed to notify the provider in writing within five (5) days of receipt of this document. The undersigned directs the insurer to pay the health care provider directly without including the patients name on the check.

- The insurer is directed, by the provider and the undersigned, to not issue any checks or drafts in partial settlement of a claim that contain or are accompanied by language releasing the insurer or its insured/patient from liability unless there has been a prior written consent settlement agreed to by the healthcare provider and the insurer as to the amount payable under the insurance policy or contract. The provider 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 agreement by the provider to accept a reduced amount as payment in full. The insurer is hereby placed on notice that this provider reserves the right to seek the full amount of the bills submitted.

- In the event the subject medical benefits are disputed by the insurer for any reason the undersigned hereby instructs the insurer to set aside any amount disputed (i.e., to escrow the money) and not pay the disputed amount to anyone, including myself, or any entity until the dispute is resolved. The insurer is instructed to immediately explain, in writing, to the above provider of any dispute. If the insurer schedules a defense examination or examination under oath (herein after “EUO”) the insurer is hereby instructed to send a copy of said notification to this provider. The provider or the provider’s attorney is expressly authorized to appear at any EUO or IME set by the insurer. The health care provider is not the agent of the insurer or the patient for any purpose.

- This assignment applies to both past and future medical expenses and is valid even if undated. A photocopy of this assignment is to be considered as valid as the original.

- I agree to pay any applicable deductible, copayments for services rendered after the policy of insurance exhausts, and for any other services unrelated to the automobile accident.

- The health care provider is given the power or attorney to endorse my name on any check for services rendered by the above provider to request any statement or examinations under oath that the patient provided to any insurer.

  Release of information: I hereby authorize this provider to: furnish and insurer, an insurers intermediary, the patients other medical providers, and the patients attorney via mail, fax or email, with any and all information that may be contained in the medical records; to obtain insurance coverage information in writing(declaration sheet) and telephonically from the insurer; request from the insurer all EOB's for all the providers and non-redacted PIP payout sheets; obtain any statements that the patient provided to the insurer, obtain copies of all medical records, including but not limited to, documents, reports, scans, notes, bills, opinions, radiographs, IME's and MRI's from any other medical provider or any insurer. The insurer is directed to keep the patients' medical records from this provider private and confidential and the insurer is not authorized to provide these medical records to anyone without the patients and the providers expressed written permission. The provider is permitted to produce my medical records to its attorney in connection with any pending lawsuits.

  Demand: Demand is hereby made for the insurer to pay all bills within 30 days without reductions and to mail the latest non-redacted PIP payout sheet and the insurance coverage declaration sheet to the above provider within 15 days.

  Certification: I certify that; I have read and agree to the above, I have not been solicited or promised anything in exchange for receiving health care. I have not received any promises or guarantees from anyone as to the results that may be obtained by aby treatment or service. I agree to the provider's prices for medical services, treatment and supplies are reasonable and customary.

  Caution: Please read before signing. If you do not completely understand this document, please ask us to explain it to you. If you sign below, we will assume that you understand and agree to the above.

  Patient's Name _____ (print)

  Patient's Signature _____ Date_____

  If patient is a minor, signature of parent/guardian_____

  Dr. Cynthia Urmos, B.S., D.C. _____