

**ASSIGNMENT OF INSURANCE BENEFITS, POWER OF
ATTORNEY AND RELEASE OF INFORMATION**

Insurer please read the following, in its entirety, upon receipt:

Health Care Provider: Kenneth S. Ross D.C. / Ross Chiropractic Center LLC
I, the undersigned patient/insured knowingly, voluntarily and intentionally assign the **rights and benefits** of my no-fault policy of automobile insurance, also known as Personal Injury Protection (PIP), and medical payments policy of insurance to the above health care provider. I understand 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 an insurance company for payment of the insured benefits. This assignment includes over due interest payments and any potential claim for common law or statutory bad faith. If the insurer disputes the validity of this assignment of benefits then the insurer is instructed to notify the provider in writing within 5 days of receipt of this document. Failure to inform the provider shall result in waiver by the insurer to contest the validity of this document. The undersigned directs the insurer to pay the health care provider directly without including the patient's name on the check.

The insurer is directed by the provider and the undersigned to **not** issue any drafts or checks in partial settlement of a claim that contains, or is accompanied by language releasing the insurer or its insured/patient from liability unless there has been a prior **written** settlement agreed to by the health care 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 payment or payment reduction, 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 insured 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, the insurer is hereby **instructed** to send a copy of said notification to the above provider. The provider or the provider's attorney is authorized to appear at any examination set by the insurer. The health care provider is not the agent of the insured 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, co-payments, for services rendered after the policy of insurance is exhausted, and for any other service unrelated to the automobile accident

Health Care Provider: Dr. Kenneth S. Ross, D.C. / Ross Chiropractic Center LLC

POWER OF ATTORNEY:

The above health care provider is hereby given the power of attorney by the undersigned to sign my name on any checks for payment for services rendered by the above provider.

RELEASE OF INFORMATION:

I hereby authorize the above provider to furnish the insurer, an insurer's intermediary, and/or the patient's attorney via mail, fax, email 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; to request all EOB's, and non-reacted PIP payout sheets for the insurer; and to obtain copies of all medical records, including, but not limited to: documents, reports, scans, notes, opinions, x-rays, MRI's from any other medical provider or any insurer. The Insurer is directed to keep the patient's medical records private and confidential. The insurer is **not** authorized to provide these medical records to anyone, including, but not limited to, third party vendors without the patient's and the provider's express written permission.

I certify that I have not been solicited or promised anything in exchange for receiving health care or that I have received any promises or guarantees from anyone as to the results that may be obtained by any treatment by the above healthcare provider.

CAUTION! Please read before signing so that you fully understand this document. Signing it will signify you understand it and agree to the terms!

Patient's Name: _____

Patient's Signature: _____
(If patient is a minor, signature of parent/guardian)

Date: _____

Healthcare Provider Signature: _____

Date: _____

Demand is hereby made for a copy of the latest non-reacted PIP payout sheet and the insurance coverage declaration sheet mailed to this provider within 30 days when applicable after payments have been made.