

**COMPREHENSIVE PAIN AND REGENERATIVE CENTER
COMPREHENSIVE PAIN AND REHABILITATION CENTER P.A.**



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ASSIGNMENT OF BENEFITS

Patients Name: _____

Accident Date: _____

I **irrevocably assign** to you, my medical provider, all of my rights and benefits under my insurance contract for payment for services rendered to me. I authorize you to file insurance claims on my behalf for services rendered to me and this specifically includes filing arbitration/litigation in your name on my behalf against the PIP carrier/health care carrier. I irrevocably authorize you to retain an attorney of your choice on my behalf for collection of your bills. I direct that all reimbursable medical payment go directly to you, my medical provider. I authorize you to act on my behalf. I **consent** to your action on my behalf in this regard and in regard to my general health insurance coverage pursuant to the “benefit denial appeals process” set forth in the NJ Administrative Code.

In the event the insurance carrier responsible for making medical payments in this matter does not accept my assignment, or my assignment is deemed invalid, I execute **this limited/special power of attorney** and appoint and authorize your collection attorney as my agent and attorney to collect arbitration demand or lawsuit. I specifically authorize that attorney to file directly against that carrier in my name or in your name as a medical provider rendering services to me and designate your collection attorney as my attorney in fact. I further grant limited power of attorney to you as services rendered to me in this matter, and hereby instruct the insurance carrier to pay you directly any monies due you for medical services you rendered to me.

I authorize you and or your attorney to obtain medical information regarding my physical condition from any other health care provider, including hospitals, diagnostic centers, etc., and I specifically authorize such health care provider(s) to release all such information to you about me, including medical reports, X-ray reports, narrative reports, and any other report or information regarding my physical condition.

Dated:

Patients Signature