CLIFTON OFFICE
1117 US Rt 46 E. Suite 301
Clifton, NJ 07013
Phone: 973-777-5444
Fax: 973-777-0304

Neil Sinha, M.D.
OFFICE
Board Certified in Pain Medicine & Anesthesiology
Dev Sinha, M.D.
Board Certified in PM&R
Saurabh K. Dang, M.D.
Board Certified in Pain Medicine & Anesthesiology
Dipan Patel, M.D.
Board Certified in Pain Medicine & Anesthesiology
Jahnna H. Levy, D.O.
Board Certified in PM&R. Interventional Spine & Sports Medicine

EDISON
25 S. Main St.
Suite 12
Edison, NJ
08837
Phone:
732-376-0330
Fax:
732-376-0331

ASSIGNMENT OF BENEFITS

PATIENT NAME:_____

PATIENT ADDRESS:_____

INSURANCE CO.:_____

NAME OF POLICY HOLDER:_____DATE OF LOSS:_____

CLAIM NUMBER:_____

I, the undersigned, hereafter referred to as “the patient” do hereby assign all of my rights and interest to Garden State Pain Control Center, hereafter referred to as “the medical provider” to pursue and obtain payment from the above named Insurance carrier. This assignment shall include but is limited to all rights available to me pursuant to the Personal Injury Protection Statues of the State of New Jersey and New York.

I, assign to the medical provider, all my rights and benefits under the Insurance contract for payment for services rendered to me. However, upon consent of both parties, shall be revocable.

I, the patient, do hereby understand and acknowledge that if I willingly refuse to comply with reasonable requests of the Insurance carrier, payment of my medical bills may be denied and will be held responsible for same.

I, the patient, authorize my bodily injury attorney to pay directly to the medical provider any monies due on my account or have same deducted from any settlement made on my behalf.

I, the patient, do hereby direct my health insurance carrier and/or other insurance carrier to issue payment on my behalf directly to the medical provider. The check should be made payable to the medical provider. Further, in the event that the health carrier and/or other Insurance carrier fails to forward the check to the medical provider, I will endorse and sign the check to the medical provider within (5) five days of the receipt of same.

I, the patient, do hereby acknowledge that I will not file suit and/or arbitration for the payment of the above provider's medical bills, unless I am requested to do so by the medical provider. I understand that the above referenced medical provider has an attorney and will collect payment on my behalf from the insurance carrier.

To prevent the Insurance carrier and/or the vendor designed by the Insurance carrier from refusing to accept my Assignment or submitting challenge to my Assignment as being Invalid. I execute this Special Power of Attorney to appoint and authorize the medical provider and counsel on behalf of the medical provider to file suit and/or arbitration directly against the insurance carrier in my name and/or allow the medical provider to amend the lawsuit and/or arbitration to include my name. I understand and acknowledge that the attorney chosen by the medical provider is to represent me individually on any claim for outstanding treatment with the medical provider in any appropriate forum. This Assignment serves as a limited retained agreement between me and the chosen attorney by the medical provider for the sole purpose of representing me on a claim for outstanding treatment. I have been advised that if any arbitration and/or lawsuit is filed in my name individually, failure to include an outstanding medical providers bills whom I have not executed an Assignment of Benefits with could make me liable for payment to the provider. In consideration, this medical provider has agreed to accept as payment in full the amount awarded and/or settled and will not seek additional payment from me. This does not preclude the medical provider from seeking additional payment from other Insurance carriers.

SIGNED:_____PATIENT
NAME:_____

DATE:_____WITNESS:_____
_____