ASSIGNMENT OF BENEFITS FORM

Provider: SPECIALTY SURGICAL CENTER OF NORTH BRUNSWICK

Insurance Carrier:

Policy Number:

Patient Name:

Claim Number:

Date of Accident:

For consideration received, the above patient hereby assigns their rights and interest in the personal injury protection endorsement of the automobile liability insurance policy or other insurance policy listed above. This assignment is given with respect to all services by the office of the above named medical provider or its employees. By assigning these benefits, I have expressly agreed that the following rights are assigned to the above named medical provider:

1. The right to collect from the insurance company the proceeds of the policy with respect to the PIP benefits mentioned above;

2. The right to file a claim directly against the insurance carrier in the name of the above named medical provider, as Assignee, and to designate an attorney;

3. I agree to fully cooperate with the Assignee in the collection of the personal injury protection claim from the insurance carrier, including full cooperation with the attorney chosen by the Assignee, the answering of interrogatories, the appearance at any deposition and the appearance at any hearing if my attendance is required.

I hereby authorize and direct my attorney to pay directly to the provider any amount owed for services rendered to me both as a direct result of this accident and by reason of any other bills that are due to their office, and to withhold such sums from any settlement, judgement or verdict which may be paid to my attorney or myself as the result of injuries for which I am seeking treatment with this provider.

I fully understand that I am directly and full responsible to the medical provider for all bills submitted by them for services rendered and this agreement is made in consideration of their awaiting payment. I further understand that such payment is not contingent on any settlement, judgement or verdict by which I may eventually recover said fee.

Patient Signature: _____

Date: _____

ASSIGNMENT OF BENEFITS FORM

Provider: **COASTAL Anesthesia**

Insurance Carrier:

Policy Number:

Patient Name:

Claim Number:

Date of Accident:

For consideration received, the above patient hereby assigns their rights and interest in the personal injury protection endorsement of the automobile liability insurance policy or other insurance policy listed above. This assignment is given with respect to all services by the office of the above named medical provider or its employees. By assigning these benefits, I have expressly agreed that the following rights are assigned to the above named medical provider:

1. The right to collect from the insurance company the proceeds of the policy with respect to the PIP benefits mentioned above;

2. The right to file a claim directly against the insurance carrier in the name of the above named medical provider, as Assignee, and to designate an attorney;

3. I agree to fully cooperate with the Assignee in the collection of the personal injury protection claim from the insurance carrier, including full cooperation with the attorney chosen by the Assignee, the answering of interrogatories, the appearance at any deposition and the appearance at any hearing if my attendance is required.

I hereby authorize and direct my attorney to pay directly to the provider any amount owed for services rendered to me both as a direct result of this accident and by reason of any other bills that are due to their office, and to withhold such sums from any settlement, judgment or verdict which may be paid to my attorney or myself as the result of injuries for which I am seeking treatment with this provider.

I fully understand that I am directly and full responsible to the medical provider for all bills submitted by them for services rendered and this agreement is made in consideration of their awaiting payment. I further understand that such payment is not contingent on any settlement, judgement or verdict by which I may eventually recover said fee.

Patient Signature: _____

Date: _____