FLORIDA PAIN AND REHABILITATION CENTER
A Prospira PainCare Center of Excellence

BILLING / ASSIGNMENT OF BENEFITS AGREEMENT

Thank you for choosing to be treated at Florida Pain and Rehabilitation Center. Our office is happy to file all insurance, as we are members of numerous medical plans. Our billing service will provide monthly statements with updated account status. **A balance may exist if:**

1. Insurance payment is pending
2. Checks were sent directly to the patient.
3. Plan does not cover charges in full (e.g. co-pays, deductibles, co-insurances)
4. Deductible has not been previously met.

BY LAW, we MUST BILL all patients for any balance remaining after insurance has been paid. Please do not hesitate to call the billing department at (352) 629-7011 if you have any questions, or if prior arrangements have been made regarding your balance.

We ask for your cooperation in promptly paying any unpaid balances and in forwarding any insurance checks to our office.

I have read the above billing policy and procedures of Florida Pain and Rehabilitation Center and fully understand the aforementioned.

Your signature at the conclusion of this agreement confirms that you have read and fully understand the right of confidentiality and the limits to that right, as well as our fee policy.

I, the undersigned Patient, have and do assign all rights and benefits of insurance of any and all applicable personal injury protection, medical payments and/or insurance to the Florida Pain and Rehabilitation Center and/or its affiliates and subsidiaries for services and/or supplies to the undersigned Patient and covered by Personal Injury Protection (P.I.P) Coverage, Worker's Compensation or other insurance coverage under my policy, in accordance with *Florida State Statute* §627.736. I have read the information herein and it is true to the best of my knowledge and belief

This Assignment includes, but is not limited to, all rights to collect benefits directly from the insurance company for services that I have received and all rights to proceed against the insurance company obligated to provide benefits, including legal suit. If for any reason the insurance company fails to make payments of benefits to which I am due. Specifically, this assignment includes the right to collect payment for the reasonable costs incurred in accordance with *Florida State Statute* §627.736.

I understand that if my insurance or any other payor fails to pay for the services rendered at Florida Pain and Rehabilitation Center, its subsidiaries or affiliates that I personally guarantee payment. If collection action regarding my outstanding balance occurs I agree to reimburse Florida Pain and Rehabilitation Center for attorney's fees and costs, court costs and prejudgment interest in the amount of 11% per annum.

I hereby instruct the insurance carrier that in the event the subject's medical benefits are disputed for any reason, including medical relatedness, reasonableness and/or necessity, that the amount of benefits claimed by Florida Pain and Rehabilitation Center is to be set aside and not disbursed until the dispute is resolved. I further instruct the insurance carrier to notify the provider immediately of any dispute as to payment so that he/she/it may exercise their legal rights. I have read the information herein and it is true to the best of my knowledge and belief

Patient's Signature _____ **Date** _____

Witness _____ **Date** _____