CENTRAL FLORIDA INJURY

Rehabiilitation
Phone: (407) 381-5100 Fax: (407) 275-9395

ACKNOWLEDGEMENT OF LIABILITY
ASSIGNMENT OF BENEFITS

The undersigned patient and/or responsible party, hereby acknowledges personal responsibility and liability for all the medical services which are provided by Central Florida Injury. This personal obligation is not affected by any obligation of insurance companies to pay health care costs. If an insurance company pays, the payment(s) shall be credited to your account. If no insurance payment is received, you are completely responsible to pay for all medical treatments. In addition to continuing personal responsibility, and in consideration of treatment rendered or to be rendered, the undersigned hereby assigns to the physician or facility named above the following rights, power, and authority.

CONSENT FOR TREATMENT: The undersigned hereby consents to provision of examination, fitness evaluations, treatment, therapies, medical and laboratory procedures, and drugs and supplies to the patient as ordered by the patient's healthcare provider Central Florida Injury, their physicians, nurse practitioners, physical therapist, certified athletic trainers or staff and acknowledges that no guarantee or assurance has been made to the results of such treatments, procedures or examinations.

RELEASED INFORMATION: You are authorized to release and to permit the examination or copying of any of my medical records, x-rays, laboratory reports, and the results of all tests of any type or character to such person(s) as the Physician and or Facility deems appropriate.

ASSIGNMENT OF RIGHTS: You are assigned to exclusive, irrevocable rights. Any cause of action that exists in my favor against any insurance company or other person or entity to the extent of your bill for total services, including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payments, and prosecute and receive penalties, interest, court costs, or other legally compensable amounts owned by an insurance company or other person or entity. I, as the patient and or responsible party further agree to cooperate, provide information as needed, and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request. The physician and or facility is also assigned the exclusive, irrevocable right to request and receive from any insurance company or health care plan any and all information and documents pertaining to my policies including a copy of such policy and my information or supporting documentation concerning or touching upon the handling, calculation, processing or payment of any claim.

DEMAND FOR PAYMENT: As to any insurance company providing benefits of any kind to me/us for treatment rendered by the physician/facility names above, you are hereby tendered the right to demand payment in full the bill for services rendered by the physician/facility named above following your receipt of such bill for services to extent such bills are payable under the terms of my/our policy for benefits, less any amount which I/we owe personally which are not payable under the terms of your policy.

THIRD PARTY LIABILITY: If patient(s) treatments for injuries are the result of the negligence of any third party, then patient(s) grant a secured interest (lien) against any recovery from such third party(s) to the extent of the bills for treatment in favor of the physician/facility named above.

LIMITED POWER OF ATTORNEY: I hereby grant to the physician facility named above power of attorney to endorse my name upon any checks, drafts, or other negotiable instrument representing payment from any insurance company representing payment for treatment and health care rendered by physician/facility. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered by physician facility. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my/our account or forwarded to my/our address upon request in writing to the physician/facility named above.

In the event that any provision of this Agreement is determined to be invalid or unenforceable, all other provisions of this Agreement shall remain enforceable.

A PHOTOCOPY OF THIS INSTRUMENT SHALL SERVE AS ORIGINAL

Signature of patient and/or responsible party:

Patient Signature: ______________________________ Date: ______________________

Print Name: ______________________________ Date of Accident: ______________________

Relationship to Patient: ______________________________