METROPOLITAN
NEUROSURGERY

ASSIGNMENT OF BENEFITS

Patient's Name: _____

Patient's D.O.B.: _____

I irrevocably assign to Metropolitan Neurosurgery Associates, P.A., (also at times referred to as MNA) all of my rights and benefits under any insurance contracts for payment for services rendered to me by MNA. I irrevocably authorize all information regarding my benefits under my insurance policy relating to any claim by MNA to be released to MNA. I irrevocably authorize MNA to file insurance claims on my behalf for services rendered to me. I irrevocably direct that all such payments go directly to MNA I irrevocably authorize MNA to act on my behalf and report any suspected violations of proper claims practices to the proper regulatory authorities.

I irrevocably authorize MNA to obtain counsel and enter legal or other action on my behalf and/or in my name, including the arbitration/dispute resolution process, to collect such sums due it should sums not be paid within the legally prescribed time frame. In the event that MNA elect to bring a lawsuit or petition for arbitration/dispute resolution against the insurance carrier, I irrevocably assign my rights title, and interest under the medical expense benefits and/or pip section of any insurance policy under which I am entitled to precede for benefits. This assignment shall allow an attorney of MNA choosing to bring suit or submit to arbitration/dispute resolution their claim for any unpaid bills for services rendered for injuries that I sustained in this or any accident.

In the event that this assignment is held invalid for any reason, I hereby authorize MNA to appoint an attorney of its choice to represent me directly against an insurer from which I may collect PIP benefits and to bring a claim in a forum of its choice. This appointment is intended on enabling the attorney to collect the bills of MNA.

The undersigned patient does hereby agree and acknowledge that he/she may receive benefit checks directly from the insurance carrier for services rendered by the provider. The undersigned patient hereby agrees to immediately forward said checks to MNA upon receipt of the same.

A photocopy of this assignment shall be valid as the original. This assignment of benefits has been explained to my full satisfaction, and I understand its nature and effect.

X_____ _____

Patient's Signature Date