ASSIGNMENT OF BENEFITS

I hereby authorize and direct you, my insurance company and/or my attorney to pay directly to ACCESS HEALTHCARE OF ORLANDO, INC. ("Assignee") such sums as may be due and owing Assignee for services rendered by reason of accident, illness, and for any other bills due Assignee, and to withhold such sums from any disabillty benefits, medical payments, No-Fault benefits, or any other insurance benefits obligated as reimbursement from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect said Assignee. In the event I do not have insurance coverage, I understand I remain personally responsible for payment of services rendered. I further give an irrevocable lien to said assignee gains any and all insurance benefits named herein and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by the Assignee. This is to act as an assignment of my rights and benefits to the extent of the Assignee's services provided. In the event my insurance company is obligated to make payment to me upon charges made by the Assignee for its services, refuses to make such payment, upon such cause of action, that I might have or that might exist in my favor against such company, authorize Assignee to prosecute said cause of action either in my name or Assignee's and further authorize Assignee to compromise, settle or otherwise resolve said claim of action as they see fit.

Direction of Payment

I hereby authorize any insurance company or attorney to pay directly to Assignee the amount of this and/or future bills for services rendered. I also agree to pay in a current manner any difference between the total charges and the amount paid by the insurance company directly to Assignee. This assignment also allows Assignee to endorse any check or draft paid to Assignee in my name for purposes of payment for services rendered to me by Assignee or its employees, or contractors or agents.

PIP Log & Declaration Sheet Request

I hereby authorize Assignee to release requested Information, which is pertinent to my case, to my insurance company or the attorney Involved in this case, pursuant to 627.4137 Florida Statutes. I hereby request a copy of the pip log and declaration sheet, which reflects the policy limits available at the time of this accident, to be provided to this Assignee. I hereby authorize this Assignee to request and receive a copy of my pip log periodically as they deem necessary. If any term or provision of this Assignment, Lien and Authorization or the application thereof to any person or circumstance shall to any extent be invalid or unenforceable, the remainder of this Assignment, Lien and Authorization, or the application of such term or provision to persons or circumstances other than those as to which it is held invalid or unenforceable, shall not be affected thereby, and each term and provision of this Assignment, Lien and Authorization shall be valid and enforced to the fullest extent of the law.

Reservation of Benefits

Be further advised, I am hereby placing you on notice pursuant to Florida case law that should you (the insurance company/carrier) deny, reduce or fail to pay any part of, or an entire bill which was submitted on my behalf from this health care provide, I (the assignor) as well as the assignee (health care provider) are requesting, in advance, that you reserve, or "act- aside," the amount reduced or denied until the dispute is resolved. Should you submit a check to this health care provider which is less than the correct contractual amount, and contains any language referring to payments as "Full and Final Payment," I have instructed this health care provider to return the check to you (the carrier) and consider the bill still due and owing (i.e. a late payment as defined in F.S. 627.736). Additionally, should the remaining amount of my benefits approach an amount where there would be insufficient funds to pay the amount reduced, or failed to pay, please notify me (the assignor) and this health care provider (the assignee).

Patients Name and Date

Signature _____

Print Name _____

Date _____

Health Care Provider

ACCESS HEALTHCARE OF ORLANDO, INC