ASSIGNMENT OF BENEFITS FORM

Pursuant to Florida Statue 627.736(5) and the applicable insurance policy, the undersigned patient hereby assigns the benefits of insurance and any and all rights and causes of action available under the policy of Major Medical insurance with ______________________Insurance Company are payable to **Dr. Joseph P Hornberger, M.S.,D.C.,P.A.** to receive payment, in full, for services rendered to the undersigned and which are payable under Medical Payments Coverage of the policy provided by________________________ Insurance company.

As prescribed by Florida Statute 627.730-627.741, all payments shall be overdue if not paid within 30 days (thirty) after the insurer is furnished written notice of the fact of a covered loss and the amount of same. All overdue payments shall bear simple interest at the rate of ten percent (10%) per annum.

By virtue of this assignment, the undersigned directs that all payments should be issued **solely** in the provider's name and forwarded directly to the office of **Dr. Joseph P Hornberger, M.S.,D.C.,P.A.**

In the event of dispute involving payment of my physician's bill, in order to maximize the benefits available under my policy coverage, and to continue to receive necessary treatment while the dispute is being resolved, I request the company adhere to the following. Assuming there is coverage remaining at the time company receives the physician's bill and the company fails to pay **Dr. Joseph P Hornberger, M.S.,D.C.,P.A.** the full amount of the treatment bill submitted , to avoid the exhaustion of coverage while this provider pursues its right under this assignment, I authorize and direct the insurance company, to set aside and place in escrow, an amount equal to the full amount of any such reduction and to hold that amount in escrow until the dispute is resolved in the appropriate forum.

It is acknowledged and agreed that in the event I have a wage loss claim, that **Dr. Joseph P Hornberger, M.S.,D.C.,P.A.** assignment takes precedence.

Further, I authorize and direct my insurance company to provide **Dr. Joseph P Hornberger, M.S.,D.C.,P.A.** an updated copy of the Medical Payments coverage payment record as needed.

It is agreed that this assignment will remain in full force until 48 hours after **Dr. Joseph P Hornberger, M.S.,D.C.,P.A.** receives written notice that it is being revoked. It is specifically agreed that any such revocation of this assignment will not apply to any treatment or associated expenses incurred on or before appropriate notice of revocation is received by **Dr. Joseph P Hornberger, M.S.,D.C.,P.A.** The undersigned agrees to pay any applicable deductible or co-payment not covered by the available Medical Payments insurance coverage. Further, the undersigned agrees to pay all outstanding balances in excess of the available coverage limits.

____
Patient Signature

____
Date

The undersigned hereby accepts the above assignment of Insurance benefits, including any and all causes of action available to the above-mentioned patient under said policy provided by ___________________________Insurance company for bills and expenses for services provided to this patient. The insurance company should make any and all payments for such bills and expenses solely to me, and sent the payment directly to my office.

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Dr. Joseph P Hornberger, M.S.,D.C.,P.A. **Date**

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