

Dr. Peter C. Madden

Chiropractic Physician

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ASSIGNMENT OF BENEFITS

Patient Name: _____

Patient Address: _____

Date of Loss: _____

Insurance Company: _____

Name of Policy Holder: _____

Policy Number: _____

Claim Number: _____

I, the undersigned, hereafter referred to as "the patient" do hereby assign all of my rights and interests to _____, hereafter referred to as "the medical provider" to pursue and obtain payment from the above-mentioned insurance carrier. This assignment shall include but is not limited to, all rights available to me pursuant to the Personal Injury Protection Statutes of the State of New Jersey.

I, the patient, do hereby acknowledge that I have an obligation to comply with and will comply with reasonable requests made of me by the insurance carrier. I, the patient, do further agree to cooperate with the attorney selected by the medical provider.

I, the patient, do hereby understand and acknowledge that if I willfully refuse to comply with reasonable requests of the insurance carrier, payment of my medical bills may be denied and I will be held responsible for same.

I, the patient, do hereby represent that I sustained injuries as a result of the automobile accident referenced above and have sought treatment from the medical provider.

I, the patient, authorized my bodily injury attorney and/or insurance carrier to pay directly to the medical provider any monies on my account, or, the same to be deducted from any settlement made on my behalf.

I, the patient, do hereby acknowledge that I will not file a PIP suit and/or arbitration for the payment of the above provider's medical bills. I understand that the above referenced medical provider has an attorney and will collect payment on my behalf from insurance carrier.

Further, should a partial payment be made on my behalf for services rendered to me by the medical provider, I agree to pay this difference or, the balance will be deducted from any settlement made on my behalf. Should there be no medical coverage; the balance due the medical provider will be paid directly from proceeds of my settlement.

Print Name: _____

Signed: _____

Print Name (Parent or Guardian): _____

Signed (Parent or Guardian): _____

Dated: _____