Atlantic Rehabilitation Center

ASSIGNMENT OF BENEFITS

THIS DOCUMENT IS A POWER OF ATTORNEY, MEDICAL RELEASE AND AN ASSIGNMENT OF BENEFITS WHICH ENABLES THE MEDICAL PROVIDER TO ACCOMPLISH THE FOLLOWING:

1) ENDORSE CHECKS
2) SIGN ANY PAPER WHICH WILL ENHANCE OR EXPEDITE PAYMENT TO PROVIDER FOR SERVICES RENDERED
3) SHALL PROVIDE THE MEDICAL PROVIDER WITH AN ASSIGNMENT OF BENEFITS
4) SHALL PROVIDE THE MEDICAL PROVIDER AN AUTHORIZATION TO PAY

POA: The undersigned hereby constitutes and appoints the above noted medical provider and the medical providers authorized agents or employees to be my lawful attorney in my name, place and stead to endorse any and all checks, drafts or money orders which are made payable to me alone or to me and the medical provider. Said endorsement and deposit may be made without my further expressed permission and also may be made without the consent of the maker of the draft. The undersigned further permits the medical provider to sign any other paper necessary to expedite payment of the medical provider=s fees for services rendered to the undersigned, including but not limited to affidavits, insurance forms, registered mail and other documents. The undersigned by these presents does give and grant the above named medical provider as attorney the full power and authority to do and perform all and every act whatsoever requisite and necessary to be done in and about the premises as fully to all intents and purposes as the undersigned might or could do to personally present insofar as the endorsing and cashing of said checks concerned as well as any other documents.

ASSIGNMENT OF BENEFITS: I,_____,do hereby **IRREVOCABLY ASSIGN** to the above named medical provider, any rights or benefits under my policy of insurance with _____, for any service and or charges provided by the above named medical provider. Pursuant to this **ASSIGNMENT OF BENEFITS**, you are hereby directed to mail any and all checks directly and solely payable to the above named medical provider at the address listed on the HCFA-1500A form in box 33. **This document is not intended in any way to be constured as a direction to pay.** As part of this **ASSIGNMENT OF BENEFITS**, I hereby instruct the insurance carrier that in the event the medical benefits are disputed for any reason, including medical reasonableness, relatedness and or necessity, that the amount of benefits in dispute be set aside and not disbursed to any other person or provider until the dispute is resolved.

IN WITNESS WHEREFORE the undersigned have hereunto set their hands, this,_____day of _____, 20____.

_____ _____

Patient=s Signature *Patient=s Name (please print)*

_____

Atlantic Rehabilitation Authorized Agent

16249 Biscayne Blvd. North Miami Beach Florida 33160 Tel: (305) 405-0400 A Fax: (305) 405-0415