San Antonio Spine and Rehab

ASSIGNMENT OF BENEFITS/CAUSE OF ACTION/PROCEEDS PAID

The undersigned patient and/or responsible party, in addition to continuing personal responsibility, and in consideration of treatment rendered or to be rendered, assigns and hcrenow sets over an assignment with an undivided interest in claims, causes of action, and/or proceeds paid to the doctor/clinic/healthcare provider named above as relates to all claims arising out of an accident which occurred on or about the _____ day of _____,200_____at or near

_____ _____ _____ _____

Street City State claim #

and against all responsible parties, their insurance companies and any an all other entities with responsibilities arising therefrom, and the following rights, power and authority:

1. **RELEASE OF INFORMATION: You are authorized to release any information you deem appropriate concerning my physical condition to any insurance companies, attorneys, or adjusters, in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by you.**

2. **IRREVOCABLE ASSIGNMENT OF RIGHTS & RIGHT OF SUBROGATION: You are assigned the exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company, and/or proceeds paid by any insurance company (including, but not limited to any liability insurance, any health insurance, uninsured/underinsured motorist insurance, personal injury protection insurance, medical benefits insurance, and workers' compensation insurance), individual or entity, for benefits or damages to the extent of your bill for total services if such benefits are owed within the terms of the policy, or damages caused by such individual or entity including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payment, and prosecute and receive penalties, interest, court cost, or other legally compensable amounts owed by an insurance company, or individual or entity, in accordance with the common law, the Texas Insurance Code or other applicable insurance or state statute. I hereby also subrogate my right against all such individuals, entities and insurance companies for benefits or damages to the full extent of your bill for total services. You may take such actions as you deem necessary including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payment, and prosecute and receive penalties, interest, court cost, or other legally compensable amounts owed by an insurance company, or individual or entity, in accordance with the common law, the Texas Insurance Code or other applicable insurance or state statute. I as the patient and/or responsible party, further agree to cooperate, provide information as needed, and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request.**

3. **DEMAND FOR PAYMENT: To any insurance company providing benefits or damages of any kind to me/us for treatment rendered by the doctor/clinic/healthcare provider named above, you are hereby tendered demand to pay in full the bill for services rendered by the doctor/clinic/healthcare provider named above within 60 days following your receipt of such bill for services to the extent such bills are payable under the terms of my/our policy or benefits, or for damages or injuries caused by such entity or individual. This demand specifically conforms with this State's Insurance Code, providing for attorney fees, penalty, court costs, and interest from judgment, upon violation. As relates to payment by Insured/Defendant or his/her liability insurance carrier and/or payment of my current policy, I hereby also direct and instruct same to make out checks to the doctor/clinic/healthcare provider and mail it as follows:**

PAYABLE TO: **San Antonio Spine and Rehab**
MAIL TO: **1313 SE Military Dr. Ste 107**
San Antonio, TX 78214

4. **THIRD PARTY LIABILITY: If patient's treatments for injuries are the result of the torts of any third party, then the patient(s) and/or responsible party grant a lien and assignment of an interest in my/our cause of action against any right of recovery from such third party to the extent of the bills for treatment, in favor of the doctor/clinic/healthcare provider named above. This lien, assignment and all bills protected thereby, are to be paid in full, at the latest, whenever patient and/or responsible party receives any recovery as a result of the aforesaid torts of such third party, whether the recovery is directly from such third party, from any insurance covering such third party, from any insurance covering patient and/or responsible party (e.g. uninsured/underinsured motorist coverages and personal injury protection /medical payments insurance), or from any other source whatsoever. It is understood and expressly agreed to, that a copy of this assignment may be delivered to the patient and/or responsible party's attorneys, the third party tortfeasor(s), and their insurance companies, the patient and/or responsible party's insurance companies, and any other person whom the doctor/clinic/healthcare provider named above deems appropriate.**

5. **STATUTE OF LIMITATIONS: The patient and/or responsible party hereby agrees that any statute of limitations applicable to any claim of the doctor/clinic/healthcare provider named above shall be tolled from the present until the latter of the final denial of the claim by the insurance company, final decision in the highest level court the claim may be taken to, or the actual discovery by the doctor/clinic/healthcare provider named above, of the receipt of any recovery by patient and/or responsible party as a result of the condition being treated hereunder.**

6. **ATTORNEYS' FEES. COURT COSTS. INTEREST: The patient and/or responsible party hereby agree that if the doctor/clinic/healthcare provider named above has to resort to any collection efforts in order to enforce this assignment and/or collection of any bills due, in addition to the damages sought, the above named doctor/clinic/healthcare provider shall recover all reasonable costs of collection, including but not limited to attorneys' fees and court costs. Additionally, if collection efforts are required, all bills will then incur interest at the rate of twelve percent (12%) per annum, compounded annually, from thirty (30) days after the date the bill was due, until paid.**

7. **UNLIMITED POWER OF ATTORNEY: I hereby grant to the doctor/clinic/healthcare provider named above the power to endorse my name upon any check, drafts, or other negotiable instrument representing payment from any insurance company representing payment for treatment and health care rendered by doctor/clinic/healthcare provider. I agree that my insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my account or forwarded to my address upon request in writing to the doctor/clinic/healthcare provider named above.**

8. **SEVERABILITY: I agree that each and every provision of this Agreement is reasonably necessary for the protection of the rights and interests of San Antonio Spine and Rehab and myself. However, should any provision of this Agreement be found to be invalid, illegal or unenforceable, or for any reason cease to be binding on any party hereto, all other portions and provisions of this Agreement shall, nevertheless, remain in full force and effect.**

A PHOTOCOPY OF THIS INSTRUMENT SHALL SERVE AS ORIGINAL

PRINTED NAME:_____/Parent_____

SIGNATURE:_____/Parent_____

DATE:_____