COMPENSATION LIABILITY FORMS

NOTICE OF ASSIGNMENT

Attorney/Insurance Company: _____

Attorney/Ins. Co Address: _____

Subscriber's Name: _____ Patient's Name: _____

Member ID #: _____ Group #: _____

Patient DOB: _____ SSN: _____

I do hereby authorize the above doctor to furnish you, my attorney/insurance carrier, with a full report of the case history, examination, diagnosis, treatment and prognosis of myself in regard to my accident/injury/ illness which occurred/began on _____.

I hereby give a lien to said doctor on any settlement, claim, judgment, or verdict as a result of said accident/ injury/illness. And authorize and direct you, my attorney/insurance carrier to pay directly to said doctor, such sums as may be due and owing to the doctor for service rendered me, and to withhold such sums from such settlement, claim, judgment, or verdict as may be necessary to protect said doctor adequately.

I fully understand that I am directly and fully responsible to said doctor for all physical therapy bills submitted by the doctor for service rendered me, and that this agreement is made solely for said doctor's additional protection and in consideration of the doctor awaiting payment. And I further understand that such payment is not contingent on any settlement, claim, judgment or verdict by which I may eventually recover said fee.

This instruction to you is assignment of my rights under medical coverage to the extent of this and any future medical billing. Any sum of money paid under this assignment shall be credited to my account and I SHALL BE PERSONALLY LIABLE FOR ANY UNPAID BALANCE TO Best Life Physical Therapy and Sports Medicine. I am also liable for any unpaid accounts for hospital, diagnostic and consultant services.

A copy of this authorization shall be considered as valid as the original

Patient's Signature: _____ DATE: _____

Witness: _____ DATE: _____

LIEN

I hereby authorize and direct you, the insurance company and/or attorney, to pay directly to Best Life Physical Therapy and Sports Medicine/ Gina Meyer, DPT, such sums as may be due and owing this office for services rendered to me, both by reason of accident, or illness and by reason of any other bills that are due this office, and to withhold such sums from any disability benefits, medical payment benefits, liability benefits, health and accident benefits, workmen's compensation benefits, or any other insurance benefits obligated to reimburse me or from any settlement judgment or verdict on my behalf as may be necessary to adequately protect said office. I hereby further give a lien to said office against any and all insurance named herein, and any and all proceeds of any settlement, judgment or verdict that may be paid as a result of the injuries or illness for which I have been treated by said office. This is to act as an assignment of my rights and benefits to the extent of the offices' services provided. I understand that I remain personally responsible for the total amounts due the office for their services.

I further understand and agree that this assignment, lien and authorization does not contribute any consideration for the office to await payments and they may demand payment from me upon rendering services at their option.

I authorize this office to release any information pertinent to my case to any insurance company or attorney to facilitate collection under this assignment, lien and authorization.

I agree that the above mentioned office be given power of attorney to endorse my name on any and all checks for payment of my doctor bill.

I further understand and agree that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment of and will reimburse this office for all costs of such collection efforts including, but not limited to all court costs and all attorney fees.

I fully understand that upon settlement, by signing this agreement and without exception, I cannot use G.S. 44.49, supplement or G.S.

44.50. The above General Statues mention recoveries for personal injury. I acknowledge my acceptance by my signature, which is witnessed and notarized to waive the use of the above General Statues. Please acknowledge this letter by signing below. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment, but will require me to make payments on my current balance.

Dated the _____ Day of _____ , 20 _____

Patient's Signature: _____

Guardian's Signature: _____

Witness Signature: _____