AUTHORIZATION AND ASSIGNMENT OF BENEFITS TO MEDICAL PROVIDER

Medical Provider: Ocoee Behavioral Health, LLC
2033 N Ocoee St
Cleveland, TN 37311

1. I authorize the RELEASE OF ANY INFORMATION concerning my health to any insurance company, attorney or adjuster as necessary to process any claim for payment to the above named medical provider's charges incurred by me. I also authorize the insurance company to furnish to the medical provider named above any information regarding my claims under the policy or Social Security Act.

2. In consideration of the above-named medical provider's rendering of treatment to me without immediate compensation therefore I authorize and I IRREVOCABLY ASSIGN MY RIGHT TO PAYMENT of the above immediate named medical provider's bill for treatment rendered to me out of the proceeds of any judgement or settlement in my case and, furthermore, from any insurance company providing coverage to me for such expenses.

3. With reference to any contracted insurance providing coverage to me for the above medical provider's treatment, I understand, authorize and agree that no payment due me under said contract of insurance shall be made to me for any other medical expenses until the above medical provider's BILL FOR MY TREATMENT IS PAID IN FULL.

4. I give assignment and lien in any claims against in any claims against a third party whose negligence may have cause my injury, up to the amount of the bill for treatment.

5. In the event any insurance company obligated by contractual agreement to make payment to me or to the physician refuses to make such payment upon demand, I hereby IRREVOCABLY ASSIGN AND TRANSFER to the medical provider any CAUSE OF ACTION that exists in my favor against any such company, and authorize the medical provider to prosecute that action either in my name or in his name and further to compromise, settle, or otherwise resolve said claim.

6. I waive the STATUE OF LIMITATIONS regarding my provider right to recover.

7. I permit a COPY OF THIS AUTHORIZATION to be used in place of the original.

8. I, hereby appoint the above named medical provider and any of their duly authorized agents and employees to endorse any and all checks, drafts or money orders which are made payable to the undersigned, for medical services or the like which have been, or are to be, performed by the medical provider.

9. I understand that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. If the insurance company does not pay the practice within a reasonable period of time, the patient will be billed.

10. I understand not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
11. I understand I am ultimately responsible for any balance on my account, regardless of full, partial, or non- payment from insurance.

NOTICE TO INSURANCE COMPANY OF ASSIGNMENT

You are instructed to PAY DIRECTLY TO THE above named medical provider at his office for all professional services rendered to me by his office. This instruction to you is an assignment of my rights under the medical coverage of the insurance policy or my rights under the third party liability claim.
Any Sum of money paid under this assignment shall be credited to my account.

Patient Signature:_____

Insured's Signature:_____
(if different or required)