Fakhoury Medical and Chiropractic Center

1009 SW 16th Lane Ocala, Fl 34471 (352) 351-3413 Fax (352) 629-6667

PIP- ASSIGNMENT OF BENEFITS

Name of Insured:_____
Date of Accident:_____
Name of Insurer:_____
PIP Policy Number:_____**Claim Number**_____
The insured assigns all of the rights and benefits of any applicable personal injury protection (PIP), Medical Payments, or other coverage provided by any insurance policy issued pursuant to Fla Statutes 627.730-627.7405, to
Fakhoury Medical and Chiropractic Center for services and supplies provided related to personal injuries suffered in an automobile accident.

I understand that I am responsible for any co-payments or deductibles not covered by the applicable personal injury protection (PIP), Medical payments, or other insurance coverage.

This assignment includes, but is not limited to: All rights to collect benefits directly from any insurance carrier obligated to provide benefits for services and supplies I have received. All rights to take legal or other action against any insurance carrier obligated to provide benefits if for any reason the insurance carrier fails to pay any benefits due; and All rights to recover attorney fees, legal assistant fees, costs, and any interest on fees and costs, for any legal or other action taken by Fakhoury Medical and Chiropractic Center as my assignee.

This is an assignment of rights only, and is not a delegation of any of my duties under the subject insurance policy.
I agree that Fakhoury Medical and Chiropractic Center may retain any attorney it chooses to bring legal action against any insurance carrier obligated to provide benefits for services and supplies I have received, and that the attorney chosen may be different than any attorney I may have handling any claim I may have for personal injuries.

I may be given a copy of this assignment to retain for my records if requested; I have read this assignment and I am satisfied that I fully understand the purpose and implications of executing this assignment and do so freely and voluntarily.

Patient Name: _____ Date Signed:_____

AUTHORIZATION TO OBTAIN PIP BENEFITS PAYOUT INFORMATION
I, the above named insured, hereby authorize and direct the above named insurer to send to Fakhoury Medical and Chiropractic Center, 1009 SW 16th Lane., Ocala, Fl 34471 (352) 351-3413 FAX (352) 629-6667, an accounting of payouts made under all claims submitted for payment under the above referenced policy relating to the automobile accident occurring on the above referenced date as those payouts occur.

Signature of Insured_____ Date Signed:_____

Fakhoury Medical & Chiropractic Center PLLC
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Ocala, Florida 34471
352-351-3413 fax 352-629-6667