

**ASSIGNMENT OF BENEFITS, AUTHORIZATION TO SETTLE CLAIM AND DIRECTION  
TO PAY MEDICAL PROVIDER DIRECTLY**

Patient Name: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Claim #: \_\_\_\_\_

By my signature below, for good and valuable consideration (including but not limited to the extension of credit to me), I hereby adding, transfer and convey to NEW JERSEY SPINE AND ORTHOPEDIC (NJSO) (hereinafter "the Provided") all of my rights, title and interest in and to medical expenses reimbursement in whatever form, including but not limited to any automobile liability medical expense payments or other health benefits indemnification and/or agreement otherwise payable to me.

This payment shall not exceed my indebtedness to the above name assignee and I acknowledge that I will timely pay any indebtedness owed by me to the assignee that is not otherwise satisfied by the above mentions assigned proceeds.

I further authorize the Provider to negotiate, collect and settle any claim with my insurance carrier or other third party with regard to these services, which authorization shall include authority to (1) request and receive from any insurer or any other party and all documentation and records that I am empowered to request regarding this claim, including without limitation any Independent Medical Examination Reports, Records Review Report, Explanation of Benefits, and Benefit Payment Sheets or Logs (PIP Payout Sheets), without regard as to whether such documentation has already been provided to me, and (2) endorse in my name any check issue for payment where benefits are assigned.

I further direct my insurer to direct all payments for services rendered by the Provider to: **NEW JERSEY SPINE AND ORTHOPEDIC**, at the address: **1200 US 22 E, SUITE 14, BRIDGEWATER, NJ 08807**

**THIS IS A DIRECT AND IRREVOCABLE ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER  
MY POLICY OF INSURANCE**

A photocopy of this form shall be considered as effective and valid as the original.

I have read the foregoing and understand and agree to each of the above provisions.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

Scott Katzman, M.D.

Steven Schiebert, D.O.

Douglas Slaughter, M.D.

Lloydine Jacobs, M.D.

Christopher McCarthy, M.D.

Carlisa Doria, PA-C

Shivani Vani, PA-C

Offer Ben Arie, PA-C

\_\_\_\_\_  
Provider's Signature

\_\_\_\_\_  
Date