

ASSIGNMENT OF BENEFITS

SUNSHINE SPINE AND PAIN, PA

WWW.SUNSHINESPINE.COM

(904)292-2700 - VOICE

(904)292-2666 - FAX

PATIENT: _____

SSN#: _____ DOB: _____

ID#: _____ GROUP#: _____

I hereby instruct and direct _____ Insurance Company to pay by check made out and mailed to:

SUNSHINE SPINE AND PAIN PA

PO BOX 24026

JACKSONVILLE, FL 32241

or

If my current policy prohibits direct payment to the Sunshine Spine and Pain, PA, I hereby also instruct and direct you to make out the check to me and mail it as follows:

PATIENT NAME

C/O SUNSHINE SPINE AND PAIN

PO BOX 24026

JACKSONVILLE, FL 32241

for the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

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

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize Sunshine Spine and Pain, PA to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Dated at _____ this _____ day of _____, 20____
(Time) (Month) (Day) (Year)

Signature of Policyholder

Witness

Print Name of Policyholder

Print Name of Witness