M. Darryl Antonacci, M.D.
Institute for Spine & Scoliosis, P.A.
3100 Princeton Pike, Bldg. 1, Suite D
(609) 912-1500

ASSIGNMENT OF BENEFITS/ LIEN

I hereby assign my right to receive payment from my insurance carrier to Institute For Spine & Scoliosis, P.A. and authorize my insurance carrier to make payment directly to Institute for Spine & Scoliosis, P.A.

I certify that the information I have reported with regard to my insurance coverage is correct and that I will promptly notify Institute For Spine & Scoliosis, P.A. of any change to such information or insurance coverage prior to the rendition of services on my behalf by Institute For Spine & Scoliosis, P.A.

I hereby authorize Institute For Spine & Scoliosis, P.A. to release information acquired in the course of my examination or treatment to my insurance carrier, attorney, case manager, and in the case of workman's compensation related services, my employer, for purposes of verifying my benefits, securing payment and related purposes.

I hereby acknowledge that Institute For Spine & Scoliosis, P.A. reserves the right to charge me a no show fee in the amount of twenty-five dollars ($25.00) per office visit or surgical appointment that is not cancelled by me or my representative at least twenty-four (24) hours prior to the scheduled appointment, I further acknowledge that any such no show fee shall be my sole responsibility and is not covered by my insurance carrier.

I direct my attorney and/or insurance carrier to pay Institute For Spine & Scoliosis, P.A. from any funds in settlement of my claim should there be any amounts due and owing at the time. I understand that if no settlement or award is made, or if, for some reason there is a balance due and owing subsequent to settlement, I will be personally and fully responsible for payment.

I hereby further give a lien to Institute For Spine & Scoliosis, P.A against any and all insurance benefits and proceeds of any settlement, judgment or verdict which may be paid to the undersigned as a result of illness or injury for which treatment has been rendered by Institute For Spine & Scoliosis, P.A. and assign Institute For Spine & Scoliosis, P.A. limited power of attorney necessary to collect such benefits.

I understand and agree that this agreement does not constitute any consideration for Institute For Spine & Scoliosis, P.A. to await payments, and that payment may be demanded from me immediately upon rendering of services at the option of Institute For Spine & Scoliosis, P.A. The lien described herein includes all deductibles, co-payment and/or co-insurance amounts to be paid to Institute For Spine & Scoliosis, P.A. while proceeding through the litigation process. Institute For Spine & Scoliosis, P.A. reserves the right to not compromise fees for services rendered at the time of litigation settlement.

Institute For Spine & Scoliosis, P.A. reserves the right to apply to all outstanding balances over 30 days old a finance charge of 16% per annum.

Signature of Patient: _____ **Date:** _____