Princeton Neurological Surgery

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ASSIGNMENT OF BENEFITS

I,_____(Print Name) hereby authorize Princeton Neurological Surgery, PC and its associates to provide medical care reasonable, usual and customary by today standards. I authorize benefits to be assigned to Princeton Neurological Surgery, PC for healthcare services provided to me by same. I hereby certify that the insurance information that I have provided Princeton Neurological Surgery, PC is true and accurate as of the date of service and that I am responsible for keeping it updated.

I hereby authorize Princeton Neurological Surgery, PC to submit claims, on my behalf, to the insurance company listed on the copy of the current insurance card I have provided in good faith.

This assignment of benefits shall automatically terminate, without formal action being taken, as soon as Princeton Neurological Surgery, PC has received payment in full and remedies under applicable regulatory guidelines for all medical care services provided to patient. I hereby authorize my insurer to assign and transfer any applicable ERISA plan benefits and rights to Princeton Neurological Surgery, PC including the right to receive any applicable plan documents/remedies, pursue appeals and litigation on my behalf. This authorization includes any other rights due me permissible under state and federal laws.

I hereby instructed and direct my insurance company to pay Princeton Neurological Surgery, PC directly. I understand under ERISA that I have the right and authority to direct where payment for services rendered is sent. If my current policy prohibits direct payment to the provider of service, I under my rights per state and federal ERISA regulations hereby instruct and direct my insurance company to provide SPD documentation stating such non-assign ability clause to myself and Princeton Neurological Surgery, PC. Upon proof of non-assign ability documentation I hereby instruct that the insurer make out the check to me and mail it directly to:

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for the professional or medical expense benefits, and otherwise payable to me under my current insurance policy as payment towards the total charges for the professional services rendered. I agree and understand that any funds I receive by my insurance company due for services rendered by Princeton Neurological Surgery, PC will be immediately signed over and sent directly to Princeton Neurological Surgery, PC

I authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. I authorize Princeton Neurological Surgery, PC to be my personal representative, which

allows Princeton Neurological Surgery, PC to: 1) submit any and all appeals when my insurance company denies me benefits to which I am entitled, 2) submit any and all requests for benefit information from my insurance company, and 3) initiate formal lawsuits, appeal or petition for arbitration to any State or Federal agency that has jurisdiction over my benefits. I also agree that any fines levied against my insurance company will be paid to Princeton Neurological Surgery, PC for acting as my personal representative.

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

Insurance Carrier:_____ ID Number:_____

Name of Policy Holder:_____ Name of Claimant: _____

X Signature of Policy Holder:_____ Signature of Claimant: _____ **X**

X Date: _____