https://cedarknollssurgicalcenter.com/

SURGICAL CENTER
AT CEDAR KNOLLS

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ASSIGNMENT OF BENEFITS

PATIENT NAME:_____

IF NF OR WC, DATE OF ACCIDENT _____

I hereby assign all my benefits and rights from insurance company _____ to the medical provider designed below. I assign all rights to pursue payment for service rendered to me by this medical procedure and the medical provider may proceed against said insurance company obligated to make payment to me or this medical provider for services rendered to me. In the event that the insurance company refuses to make such payment upon demand, I expressly give permission for a cause of action to be brought in my name as assignee.

A Photocopy of this assignement may be vailed if it were an original.

I agree never to recind this document and that a recession will not be honored by my attorney. I hereby instruct that if another attorney is substituted in this matter, the new attorney honor the within assigment.

_____ _____

PATIENT'S NAME (Please Print) Date

_____

PATIENT'S SIGNATURE

NORTHERN ANESTHESIA
PO BOX 95000-2555
PHILADELPHIA, PA 19195-2555