

## ASSIGNMENT OF BENEFITS

I authorize and direct my Insurer or Payor to pay directly to Northern Jersey ENT Associates and the Physicians any or all benefits that would otherwise be payable to me (or the patient if signed by a responsible party), up to the amount of my bill, accruing to me in connection with my treatment at Northern Jersey ENT Associates.

I request that payment of my authorized health insurance policy benefits for services furnished to me by Northern Jersey ENT Associates be made on my behalf to Northern Jersey ENT Associates. In the event that payments are made to Northern Jersey ENT Associates and to me as Joint Payees, I agree to cooperate with Northern Jersey ENT Associates to ensure that the Practice receives all amounts due to the Physicians.

I hereby authorize Northern Jersey ENT Associates to pursue any means necessary to collect all charges on my account including follow-up calls, appeals, arbitration and civil suits, if allowable under law. In the event that Northern Jersey ENT Associates or the Physician elect to bring an appeal, lawsuit, or petition for arbitration against the Insurance Carrier, I hereby assign to them my rights, title, and interest under any insurance policy under which I am entitled to proceed for benefits, if allowable under law. This Assignment shall allow an attorney of their choosing to bring suit or submit to arbitration their claim of any unpaid or underpaid bills for treatment rendered at Northern Jersey ENT Associates.

I agree that, if I receive any monies directly from the insurance carrier, I will forward them promptly to Northern Jersey ENT Associates.

I understand that, if I do not forward money that is received by the carrier promptly, Northern Jersey ENT Associates will bill me for the full amount of the services rendered.

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SIGNATURE

\_\_\_\_\_  
DATE