



Patient name: _____

Irrevocable Assignment of Benefits, Instruction and Authorization for Direct Payment to Physician

Attorney, insurance carrier and/or insured:

Address _____

City, State, Zip _____

Phone number _____ Fax number _____

Insurance Company Name _____

Insurance Company Address _____

Adjuster Name _____

City, State Zip _____ Phone number _____

Claim number _____ Date of Injury _____

In consideration for the professional services provided to me by Dr. Radnovich, D.O., P.C. doing business as Injury Care Medical Center (hereafter 'Provider'), I hereby assign my cause of action and right of recovery on any settlement claim, judgment or verdict as a result of the accident/injury dated herein. I further instruct/direct the above attorney, insurance carrier and/or its insured (hereafter 'Third Party') to pay Provider in full for all charges incurred and submitted for diagnostic testing, treatment, treatment supplies and/or interest accrued; that relate to injuries sustained in the accident on _____ (date of injury) out of proceeds of the settlement of my claim against the above named insurance carrier and its insured.

I recognize that I am not an insured of the above named insurance carrier and currently have no rights in the policy. However, once a settlement of my claim against the above named carrier and its insured is reached, I will have an enforceable right to payment from the above named insurance carrier and/or its insured that arises to the level of an enforceable property right. By signing this document I therefore agree to assign this enforceable property right to Provider up to that amount owed for services provided to me and interest accrued, relating to this accident. This assignment shall take precedence over other verbal or written agreements of settlement between the insurance carrier named above, it's insured, and myself. I hereby demand that the above named insurance carrier and/or its insured deduct these sums owed to Provider directly from my settlement prior to any payments made to me.

I agree that by signing this document the above named Third Party is put on notice that if the above named Third Party neglects to pay Provider for these services prior to any payment made to me, the Third Party will be subject to a claim for tortuous interference with this contract between Provider and myself as well as to seek any other relief the court may allow under any other current law. I agree in advance that Provider, as a party to this contract may proceed with such a claim if payment is not made to him according to this instruction/demand.



Patient name: _____

I agree that payment made to me by the Third Party for sums owed to Provider will **not** be deemed payment to Provider whether the intent of such payment to me was made in lieu of payment to Provider or not.

In consideration of the services which have already been performed, those services that will be performed prior to settlement of the claim with the above named insurance carrier or its insured, and in consideration of Providers willingness to await payment until settlement and his reasonable reliance upon this agreement, these instructions/demand for direct payment to Provider shall be irrevocable and continuous.

Return all payments to:
Richard Radnovich, D.O., P.C.
Injury Care Medical Center
4850 N. Rosepoint Way Suite 100
Boise, Idaho 83713 (208)939-2100

_____ I authorize said Provider to release any information pertinent to my case to the mentioned insurance carrier

_____ A photocopy or scanned copy of this authorization shall be considered as valid as the original.

_____ I authorize said Provider to use my name in the "signature file" in future billings

_____ I authorize direct payment to above Provider out of settlement proceeds with the above named Third Party and/or their assignees

_____ I authorize use of this form on all my insurance submissions (billings).

Guardian Name (if patient is a minor) _____

Patient Signature
(and guardian signature if patient is a minor) _____

Date _____ Witness Initial _____