PAIN INSTACARE®
Gupta Institute
"Best Pain Relief Possible"
CALL TOLL FREE (888) PAIN-121

PAIN INSTACARE
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RAJAN GUPTA, MD
Board Certified in Pain Management
Board Certified in Physical Medicine & Rehabilitation
"Best Hands Award"
"Prestigious Pillar of Community Award"
"Top Doc Award 2015, 2016, 2017"

Irrevocable Assignment of Benefits/Guarantee to Cooperate

In consideration of services rendered or to be rendered to the patient named below, I hereby authorize and assign payment directly to the office of Pain Instacare / Gupta Institute for Pain Wellness & Rehabilitation, of any and all first party no-fault automobile insurance benefits to which I am otherwise entitled for services rendered by the provider. This medical office in turn agrees to comply with the requirements of the no-fault insurance carrier's precertification plan/decision point review plan and; and the medical office agrees not to seek to obtain payment from the insured or persons receiving treatment or undergoing medical testing whenever charges have been reduced in accordance with the no-fault carrier's precertification plan.

I authorize, assign and direct payment of insurance benefits to the following provider office Pain Instacare / Gupta Institute for Pain Wellness & Rehabilitation, for monies due on bills, which relates to services rendered. I assign to the above provider's office, the right to prosecute the claim(s) against the insurance carrier who affords benefits and I agree to fully cooperate with this provider's offices efforts to prosecute a claim against the insurance carrier, if there is not timely payment on the claim.

In the event the provider's charges are outstanding and I fail to file an application for benefits under the State No-Fault laws, I hereby authorize the providers to file such a claim in my behalf so that the provider may realize payments of its charges. I also authorize the above referenced provider to release any medical information necessary for the use of attorney's, doctors, insurance companies or collection services.

As part of my assignment of benefits, I specifically request that my insurance carrier forward to the provider copies of any and all reports from Independent Examiners, Peer Review Doctors and auditing companies.

Additionally, should I recover any money by virtue of claim or legal cause of action, I hereby assign my right to payment directly to the health care provider named above and I direct my attorney or other legal representative to honor this irrevocable assignment as a lien on my file or any funds that may be due me. My attorney or legal representative is hereby authorized and directed to make such payment from the recovery in such claim or action up to the amount due to the above provider so as to be consistent with this assignment. This assignment will also serve as a letter or protection for the provider, which grants the provider the ability to recover outstanding balances, which are not due to fee scheduling reductions, from any and all settlements I may recover.

I understand that the above assignment may not be revoked or amended without the express written consent of the above-mentioned provider. Additionally, by signing this agreement I fully understand the terms contained therein. My signature also represents that I fully understand this agreement if I needed assistance interpreting it. I have not been coerced in any way to give this assignment. If any portion of this form is found to be invalid, the remainder shall remain in effect. A photocopy of this shall be deemed as valid as an original.

PATIENT NAME: _____ Signature: _____

CLAIM NUMBER: _____DATE OF INJURY: _____

TODAYS DATE: _____

ABNform-2024