SPORTS & SPINE INJURY CENTER
Dr. August J. La Ruffa
654 West Indiantown Road, Suite 107
Jupiter, FL 33458

ASSIGNMENT OF INSURANCE BENEFITS, POWER OF ATTORNEY AND MEDICAL RELEASE

Insurer, please read the following in its ENTIRETY upon receipt

POA: The undersigned hereby constitutes and appoints the above noted medical provider and the medical provider's authorized agents or employees to be my lawful attorney in my name, place and stead to endorse any and all checks, drafts, or money orders which are made payable to me alone or to me and the medical provider. The undersigned further permits the medical provider to sign any other paper necessary to expedite payment of the medical provider's fees for services rendered to the undersigned, including, but not limited to, affidavits, insurance forms, registered mail and other documents.

RELEASE OF MEDICAL RECORDS: The undersigned does hereby authorize and request that upon receipt of this document or any photocopy thereof, and all physician, surgeon, hospital, ambulance owner, nurse, aid, or other health care worker or holder of documents to furnish and provide to any agent of the above medical provider all information, records, and evidence in their possession regarding my care, condition, bill, statement of account and charges to date, anticipated additional charges, nature and extent of disability and all subsequent matters and developments and or treatment of the undersigned, while under continuing and/or completed care of the above noted medical provider. A photocopy of this document shall be as binding as an original signature page. The undersigned does hereby ratify and confirm any and all actions taken by the above medical provider in accordance with this special power and which the said medical provider shall do or cause to be done by virtue of these presents.

ASSIGNMENT OF BENEFITS: I, _____, do hereby knowingly, voluntarily and intentionally IRREVOCABLY ASSIGN to the above named medical provider, any rights or benefits under the No-Fault Policy of Automobile Insurance, also known as Personal Injury Protection (PIP) or Medical Payments policy, my policy of insurance from my automobile insurer for any and all services rendered to the undersigned patient/insured by the above named medical provider. Pursuant to the **ASSIGNMENT OF BENEFITS**, you are hereby directed to mail any and all checks directly and solely payable to the above named medical provider. Any partial or reduced payment issued by the insurer and deposited by the provider shall be done so under protest and the deposit shall not be deemed a waiver, accord, satisfactions, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full. This document is not intended in any way to be construed as a direction to pay. As part of this **ASSIGNMENT OF BENEFITS**, I hereby instruct the insurance carrier that in the event the medical benefits are disputed for any reason, including medical reasonableness, relatedness and or necessity, that the amount of the benefits in dispute be set aside and not disbursed to any other person or provider until the dispute is resolved.

Caution! Please read before signing. If you do not completely understand this document, please ask us to explain it to you. If you sign below, we will assume you understand and agree to the terms.

_____ _____
Patient's Signature **Date**

_____
Patient's Name (Please Print)

_____ _____
Doctor's Signature (or Authorized Agent) **Date**

FEE GUARANTEE AGREEMENT FOR
Sports & Spine Injury Center and/or August LaRuffa, D.C.

PATIENT:_____

CLAIM #: _____

TREATMENT DATES: _____

ACCIDENT DATE: _____

I, the above noted Patient, do hereby authorize and direct my present and any future attorney to honor this fee guarantee agreement. This agreement is made in favor of the above named Medical Provider and all his related medical treatment entities and shall be termed a "Letter of Protection." The Letter of Protection shall serve to place a continuing lien on any proceeds I recover in any legal action related to the above noted accident date.

Consideration. In consideration of the medical treatment provided and time provided to pay for said medical treatment, I hereby grant a direct lien on any and all funds I may recover in any legal action.

Protection of Outstanding Charges. The above named Patient hereby agrees that if s/he recovers any money from any person, corporation, enterprise or entity in connection with any legal action the Patient shall withhold from any of those funds sufficient money to pay the full outstanding balance of any bill(s) owed to the above named Medical Provider for treatment or any work completed in relation to the above noted accident date. Those funds shall be deducted prior to any other party removing funds for any reason, including but not limited to attorney's fees, costs, other court fees, or any other bill or lien whatsoever. Patient hereby directs their present and/or future attorney to pay said outstanding medical bill in connection with the above noted treatment. This agreement shall obligate each attorney who represents the above named patient in any way and recovers any funds related to the above noted accident date and creates a constructive trust with said attorney. Further, this agreement shall extend to include payment of any outstanding balance Patient may have to the Medical Provider for any copies, costs or reports, expert witness opinions, travel, or any other cost(s) the above named Medical Provider endures in relation to any legal issue for the Patient. The Patient hereby agrees to waive any rights they have, under contract, law or equity, to have the Medical Provider bill a third party entity, including but not limited to any contracted payer, health insurer or government payer and further desires to pay for the medical treatments through the proceeds Patient obtains in the legal action(s). Interest shall accrue on any unpaid balance at the highest interest permitted by law, or the amount which the Medical Provider determines, whichever is lower.

Patient Responsibility. It is the Patient's responsibility to advise each and every attorney of the existence of this agreement. The Patient must advise the above named Medical Provider at reasonable intervals as to the status of the legal case. It is also the Patient's responsibility to advise the Medical Provider within 5 days of legal matter collecting any funds and shall then request a bill from Medical Provider for any and all outstanding charges. The Patient hereby directs their present attorney and any future attorney to advise the Medical Provider, as soon as possible, about any funds related to any legal matter becoming available to the above named Patient. Further, if the legal action fails to fully pay the Medical Provider's outstanding balance(s) then the remaining amounts are to be paid by the Patient. The Medical Provider may, at his/her discretion, at any time, bill any third party payer, first party payer, contracted payer or government payer.

Disputes. If there is a dispute over the Medical Provider's outstanding charges the Patient agrees to submit the full amount due to the Medical Provider and agrees to bring an action in Florida State Court for recovery of the disputed difference. The Patient directs their attorney not to place the funds in the court registry but rather to submit the full bill to the Medical Provider and then bring suit for the difference. If the Patient fails to pay the Medical Provider's full outstanding balance, and thereafter Medical Provider brings suit to collect said sums, Medical Provider shall then have the right to recover attorney fees and costs for bringing an action to enforce this particular provision.

Approval Required. This agreement becomes effective when the Patient signs the agreement below. This agreement does not need the approval of any present or future attorney for the Patient. Further, the parties agree that no party shall be considered the drafting party to this contract.

_____ _____
PATIENT NAME (PRINT) DATE

_____
PATIENT SIGNATURE

_____ _____
MEDICAL HEALTH PROVIDER DATE