INTEGRA
Rehabilitation Physicians

Assignment of procedures; lien and authorization

I hereby authorize and direct any and all Insurance carriers, attorneys, agencies, governmental departments, companies, individuals, and /or legal entities, which may elect or be obligated to pay, provide or distribute benefits to me for any medical conditions, accidents, injuries or illnesses, past present or future to pay directly and exclusively to Integra Rehabilitation Physicians, PLLC such sums as may be owing to Integra for charges incurred by me at the office related to my condition, with such payments to be made exclusively in the name of Integra Rehabilitation Physicians, PLLC I further grant a lien to Integra Rehabilitation Physicians with respect to my charges. This lien shall apply to all payers and to the full extent permitted by law. For purposes of this document, "benefits" shall include, but not limited to , proceeds from any settlement, judgment, or verdict as well as any proceeds relating to commercial health or group insurance, medical payments, third party liability distributions, disability benefits, worker's compensation benefits, and any other benefits or proceeds payable to me for the purposes stated herein.

I authorize Integra Rehabilitation Physicians, PLLC to release any information regarding my treatment or pertinent to my case(s) to all payers as defined above to facilitate collection under this agreement and lien. I further authorize and direct all payers to release to Integra Rehabilitation Physicians any information regarding any coverage or benefits which I may have including, but not limited to the amount of coverage, the amount paid thus far and the amount of any outstanding claims. I hereby direct this office to file a copy of this agreement and lien together with any said payers. I hereby grant Integra Rehabilitation Physicians, PLLC power of attorney to endorse/sign my name on any and all checks listing me as a payee which are presented to Integra for payment of an account relating to me, my spouse or any of my dependents. I further authorize Integra Rehabilitation Physicians, PLLC to apply and credit balances incurred by me to any other outstanding charges still owed by me, my spouse, or my dependents, regardless of these other charges related to my condition.

I understand that I remain personally responsible for the total amounts due to Integra for their services. This assignment and lien does not constitute any consideration for this office to await payments and it may demand payments from me immediately upon rendering services at its option. If this office must take action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse Integra Rehabilitation Physicians, PLLC for all costs of such collection efforts, including but not limited to all court costs and attorney fees.

The assignment and lien shall not be modified or revoked without the mutual written consent of Integra Rehabilitation Physicians, PLLC and myself. I hereby revoke any previously signed authorizations, whether executed at this or any other office to the extent that terms of those authorizations conflict with the terms of this assignment and lien.

Patient Signature: _____ Date: _____

Parent/Legal Guardian Signature: _____ Date: _____

Custodial Parent or Legal Guardian Name (Please print) _____