

Accident Care & Treatment Center, Inc.
3209 NW Expressway
Oklahoma City, OK 73112

Assignment of Benefits

RE: Patient Name: _____ (DOI) _____
Address: _____
Phone: (H) _____ (W) _____ (C) _____

I hereby instruct and direct the payment of all professional or medical expense benefits allowable and otherwise payable to me under my insurance policy to Accident Care & Treatment Center, Inc., 3209 NW Expressway, Oklahoma City, OK 73112 as payment for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY BENEFITS UNDER THIS POLICY. I understand that this payment will not exceed my indebtedness for services rendered. If my current policy prohibits direct payment to my medical provider, then I hereby also instruct and direct the insurance provider to make out the check to me and mail it to Accident Care & Treatment Center, Inc., 3209 NW Expressway, Oklahoma City, OK 73112.

I further understand that I have a choice in medical providers. If I decide to obtain treatment from Southwest Regional Imaging and Radiology, LLC, Injury Recovery Physical Therapy, LLC, and/or Interventional Radiology Associates, LLC, I hereby instruct and direct the payment of all professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy to Southwest Regional Imaging and Radiology, LLC, Injury Recovery Physical Therapy, LLC, and/or Interventional Radiology Associates, LLC, Inc., 3209 NW Expressway, Oklahoma City, OK 73112 as payment for services rendered. THIS IS A DIRECT ASSIGNMENT OF MY BENEFITS UNDER THIS POLICY. I understand that this payment will not exceed my indebtedness for services rendered. If my current policy prohibits direct payment to my medical providers, then I hereby also instruct and direct the insurance provider to make out the check to me and mail it to Southwest Regional Imaging and Radiology, LLC, Injury Recovery Physical Therapy, LLC, and/or Interventional Radiology Associates, LLC at 3209 NW Expressway, Oklahoma City, OK 73112.

A photo copy of this Assignment shall be considered as effective and valid as the original.

If there is no payment by the insurance carrier or if partial payment is made, I understand I will be responsible for payment on any outstanding balance incurred by me for medical services rendered.

Date: ____ / ____ / ____

Patient

Witness – Accident Care & Treatment Center