Advanced Diagnostic Medical Imaging, Inc.

1921 West Dr. Martin Luther King Jr. Blvd Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tampa, FL 33607 ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: (813) 609-4936 Group#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax: (813) 489-7017

I hereby assign, instruct, and direct any and all benefits payable by Patient’s insurance or healthcare plan(s) as a result of charges incurred by Patient for services rendered by this Provider be made payable to:

Advanced Diagnostic Medical Imaging, Inc.

1921 West Dr. Martin Luther King Jr. Blvd

Tampa, FL 33607

and mailed to Provider address. Or, if my current policy prohibits direct payment to Provider, I hereby also instruct and direct you to make out the check for this claim payable to me and mail it to the temporary address as follows:

Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

c/o Advanced Diagnostic Medical Imaging , Inc.

1921 West Dr. Martin Luther King Jr. Blvd

Tampa, FL 33607

In the event \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ receives any check, draft, or other payment subject to this Agreement, such monies will be held in trust for Provider. Patient will immediately deliver said check, draft, or payment to Provider. Any violations of this agreement will, at Provider’s election, terminate Patient charge privileges with Provider and bring any balance owed by Patient to Provider immediately due and payable.

For the professional or healthcare expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize the Provider to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

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Signature of Policyholder Patient /Guardian Printed Name

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Dated Witness