EZ Rehab SOLUTIONS

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A PAIN MANAGEMENT AND OCCUPATIONAL REHAB CLINIC

You are hereby authorized to disclose and/or furnish my attorney(s) with any and all medical information, bills, and/or records in your possession which they request in reference to any illnesses and injuries which I have suffered.

I further, irrevocably assign to you, and authorize and direct said Attorney to pay from the proceeds of any recovery in my case all reasonable fees for services provided by you, including fees for preparation and testimony, as a result of the injury or condition heretofore mentioned. I understand that this in no way relieves me of my personal primary obligation to pay for such services and that the signing of this form does not prohibit customary billing by you. All bills shall be paid promptly in the usual manner. This specifically includes but is not limited to any and all Pip, Med-Pay, or Med-Expense payments.

I further agree that any applicable statute of limitations will not begin to run until there is a denial in writing by me of any balance claimed to be due and owing, mailed via certified mail to you, by me.

Patient Signature: _____ (seal)

Print Name: _____ _____ _____ ____ __ (Seal)

Witness: _____ Date: _____

THE UNDERSIGNED ATTORNEY FOR THE PATIENT REFERRED TO ABOVE HEREBY AGREES TO COMPLY FULLY WITH THE FOREGOING "AUTHORIZATION AND ASSIGNMENT" AND AGREES TO ADVISE THE NAMED ASSIGNEE IN WRITING THE STATUS OF THE CLAIM OF THE PATIENT WITHIN TEN (10) DAYS OF THE REQUEST, AND AGREES TO NOTIFY THE ASSIGNEE IF THE ATTORNEY CEASES TO REPRESENT THIS PATIENT AND/OR IF THE CLAIM IS DROPPED OR DENIED.

Attorney: _____ Date: _____ _____ __

Print Name: _____ _____ _____ ____ ____