

**DIRECT IRREVOCABLE ASSIGNMENT OF BENEFITS**

DATE: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_

CLAIM #: \_\_\_\_\_

I HEARBY INSTRUCT AND DIRECT \_\_\_\_\_ INSURANCE  
COMPANY TO PAY BY CHECK MADE PAYABLE AND MAILED TO:

**ARI GLOBERMAN, LMT BACK TO LIFE, P.A.  
11903 SOUTHERN BLVD., SUITE 212  
ROYAL PALM BEACH, FLORIDA 33411  
LICENSE #MA-42478 TAX ID# 11-3746865**

IF MY CURRENT POLICY PROHIBITS DIRECT PAYMENT TO MEDICAL PROVIDER, I HEARBY ALSO INSTRUCT AND DIRECT YOU TO MAKE THE CHECK PAYABLE TOME AND MAIL IT TO THE ABOVE MEDICAL PROVIDER.

I \_\_\_\_\_ HEREBY **IRREVOCABLY ASSIGN** TO THE ABOVE NAMED MEDICAL PROVIDER ANY RIGHTS AND BENEFITS UNDER ANY POLICY OF INSURANCE, INDEMNITY AGREEMENT OR ANY OTHER COLLATERAL SOURCE AS DEFINED IN FLORIDA STATUTES FOR ANY SERVICE AND OR CHARGES PROVIDED BY THE ABOVE NAMED MEDICAL PROVIDER. YOU ARE HEREBY DIRECTED TO MAIL ANY AND ALL CHECKS PAYABLE TO THE ABOVE MENTIONED PROVIDER AT THE ADDRESS LISTED ON THE HCFA 1500 FORM IN BOX 33. **THIS IS A DIRECT IRREVOCABLE ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THE 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 THE INSURANCE PAYMENT.

**ADDITIONALLY, THIS MEANS THAT IF YOU, MY INSURANCE COMPANY, \_\_\_\_\_, NEGLECTS THIS DOCUMENT THAT I HAVE EXPLICITLY AUTHORIZED AND DEMANDED YOU TO HONOR, AND YOU STILL SEND THE CHECK FOR THE ABOVE MENTIONED PROVIDER'S SERVICES' TO ME AT MY MAILING ADDRESS, MADE PAYABLE TO ME, I WILL IMMEDIATELY FORWARD THAT CHECK TO THIS PROVIDER AND I GIVE THEM "POWER OF ATTORNEY" TO ENDORSE SAID CHECK.**

**IN WITNESS WHEREFORE, THE UNDERSIGNED HAVE HEREUNTO SET THEIR HANDS, THIS \_\_\_\_\_ DAY OF \_\_\_\_\_, 20\_\_.**

**PATIENT SIGNATURE**

---

**WITNESS**

---