Cyrus R Vosough, M.D.
510 Hamburg Turnpike
Suite 205
Wayne, New Jersey 07470

(973)595-0063

ASSIGNMENT OF BENEFITS FORM

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize payment directly to Cyrus R Vosough, M.D. of the insurance benefits herein specified and otherwise payable to me but not to exceed the balance due on the regular charges. I understand that I am financially responsible to Cyrus R Vosough, M.D. for charges not covered by this authorization. Should this account be referred for collection after a default, the undersigned agrees to pay costs of collection, including a reasonable attorney's fee. All delinquent accounts have interest of legal rates.

Medicare Benefits:

I request that payment of authorized benefits be made on my behalf for any services furnished me by Cyrus R Vosough, M.D. I authorize any holder of medical or other information about me to release to the Healath Care Financing Administration and its agents, any information needed to determine these benefits or those to related services.

Medicaid Benefits:

I certify that I am a recipient of the Medicaid, Title XIX program, and request that payment of authorized benefits is made on my behalf, I authorize Cyrus R Vosough, M.D. to make available to the Division of Family Services any required information concerning medical insurance, and financial records relating to my treatment. I hereby certify all health insurance shall be assigned to Cyrus R Vosough, M.D. for services provided.

_____	_____	_____
Patient's Signature	Date	Print Patient's Name
_____	_____	_____
Signature of Person Authorized To Sign	Date	Print Name of Authorized Person
_____	_____	_____
witness	Date	Relationship to Patient

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ASSIGNMENT OF BENEFITS FORM

RE: AUTOMOBILE ACCIDENT:

Date of Accident: _____

For consideration received, I, _____, assign to Cyrus R Vosough, M.D. _____ my rights and interest in the personal injury protection endorsement of the automobile liability insurance policy or other insurance policy listed above. This assignment is given with respect to all treatment, care and diagnostic treatment given by the assignees to or its employees. By assigning these benefits, I have expressly agreed that the following rights are assigned to the assignee:

1. The right to collect from the insurer the proceeds of the policy with respect to the PIP benefits mentioned above.

2. The right to file a lawsuit directly against the insurance company in the name of the assignee, as Assignee, and the designate an attorney of their choosing for the purpose of filling said lawsuit.

3. I agree fully to cooperate with the Assignee in the collection of the personal injury protection claim from the insurance carrier, including full cooperation with the attorney chosen by the Assignee, the answering of any interrogatories, the appearance at any deposition and the appearance of any arbitration or trial if my attendance is required.

   I hereby authorize and direct to you, my attorney, to pay directly to the assignee, such sums as may be due and owing them for medical/dental services rendered me both by reason of this accident and by reason of any other bills that are due their office, and to withhold such sums from any settlement, judgment or verdict which may be paid to you, my attorney, or myself as the result of injuries for which I have been treated or injuries in connection therewith.

   I fully understand that I am directly and fully responsible to the assignee for all medical bills submitted by them for service rendered and this agreement is made solely for the assignee additional protection and in consideration of their awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee, and that a payment on the account is due and payable upon demand.

_____	_____	_____
Patient's Signature	Date	Print Patient's Name
_____	_____	_____
Signature of Person Authorized To Sign	Date	Print Name of Authorized Person
_____	_____	_____
Witness	Date	Relationship to Patient

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ASSIGNMENT OF BENEFITS FORM

RE: WORKMEN COMPENSATION

Date of Injury: _____

For consideration received, I, _____, assign to Cyrus R Vosough, M.D. _____ my rights and interest in the personal injury protection endorsement of the liability insurance policy or other insurance policy listed above. This assignment is given with respect to all treatment, care and diagnostic treatment given by the assignees to or its employees. By assigning these benefits, I have expressly agreed that the following rights are assigned to the assignee:

1. The right to collect from the insurer the proceeds of the policy with respect to the injured benefits mentioned above.

2. The right to file a lawsuit directly against the insurance company in the name of the assignee, as Assignee, and the designate an attorney of their choosing for the purpose of filling said lawsuit.

3. I agree fully to cooperate with the Assignee in the collection of the personal injury protection claim from the insurance carrier, including full cooperation with the attorney chosen by the Assignee, the answering of any interrogatories, the appearance at any deposition and the appearance of any arbitration or trial if my attendance is required.

   I hereby authorize and direct to you, my attorney, to pay directly to the assignee, such sums as may be due and owing them for medical/dental services rendered me both by reason of this accident and by reason of any other bills that are due their office, and to withhold such sums from any settlement, judgment or verdict which may be paid to you, my attorney, or myself as the result of injuries for which I have been treated or injuries in connection therewith.

   I fully understand that I am directly and fully responsible to the assignee for all medical bills submitted by them for service rendered and this agreement is made solely for the assignee additional protection and in consideration of their awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee, and that a payment on the account is due and payable upon demand.

_____	_____	_____
Patient's Signature	Date	Print Patient's Name
_____	_____	_____
Signature of Person Authorized To Sign	Date	Print Name of Authorized Person
_____	_____	_____
Witness	Date	Relationship to Patient