CENTRAL JERSEY REHABILITATION MEDICINE, L.L.C.

PATIENT ASSIGNMENT OF BENEFITS AND PAYMENT GUARANTY

Patient Name:	Medical Record #
Address:	

I irrevocably assign to **Central Jersey Rehabilitation Medicine, L.L.C.** ("CJRM") and its providers all of my rights and benefits and any other interests that I do or might have in any medical insurance plan, health benefit plan, indemnity plan, trust, fund or other source of payment for health care services (each a "Plan"), in connection with medical services provided by CJRM, its employees and agents. I understand that this document is a direct and irrevocable assignment of my rights and benefits under my Plan(s).

I instruct my Plan(s) to pay CJRM directly for the health or medical expense benefits payable to me. If my current Plan(s) prohibit(s) direct payment to CJRM, I understand and agree that I am responsible for full payment to CJRM and will immediately turn over to CJRM any payment for services rendered by CJRM that is received by me from my Plan(s).

I acknowledge and agree that I am responsible for all charges for services provided to me which are not covered by my Plan(s) or for which I am responsible under my Plan(s). To the extent no coverage exists under my Plan(s), I acknowledge and agree that I am responsible for all charges for services provided and agree to pay all charges. I understand that this is a guaranty of payment.

I authorize CJRM and its agents to release any medical or other information about me in its possession to my Plan(s), including, but not limited to, the Social Security Administration, CMS, State Medicaid plans, and their intermediaries, as required or in connection with any claim for services rendered to me by CJRM, its employees or agents. This authorization includes disclosure and action as necessary for CJRM to collect any debt I may owe to CJRM, including claims submission and processing, appeals, arbitration, mediation, litigation and collection.

A photocopy of this document shall be considered as effective and valid as the original.

I have read and understand this document. I have had an opportunity to ask questions about the contents of this document. I acknowledge and agree to the terms and conditions of this document.

Patient Name _____ Date _____

Patient Signature _____

Authorized Individual (Parent/Guardian) Name _____

Authorized Individual Signature _____

Basis of Authority (e.g., parent, guardian): _____

(Authorized individuals will be required to provide proof of authority.)