ASSIGNMENT OF BENEFITS

PATIENT'S NAME: _____ DOB: _____ S.S#_____

MULTICARE HEALTH CENTER LTD.

In consideration of your undertaking to render care, I agree to the following:

Release of Information:
You are authorized to release any information you deem appropriate concerning my medical condition to any insurance company, attorney, adjuster or any other person necessary for you to process any claim for reimbursement of charges incurred by me at Multicare Health Center.

Right to Receive Payment:
I authorize and assign you, the medical provider, and treating facility Multicare Health Center, the right to receive direct payment from my attorney, insurance company or any other party who may become obligated to pay me any sums. I further authorize endorsement of my name to any draft containing my name to which you are legally entitled.

Assignment of Right to Sue:
In the event that any insurance company, attorney or other person obligated by contractual agreement to make payment to me for your services, refuses to make such payment upon demand by you, I hereby assign and transfer Multicare Health Center, the cause of action that exists in my favor against such company, attorney or person and authorize you to prosecute said action either in my name or your name and for you to resolve said claims as you see fit. I understand that I shall continue to remain responsible for any uncollected or unpaid balance on my account. I also understand that a 33% collection fee, in addition to attorney's fee, in addition to attorney's fees will be collected upon demand.

Attorney Direction:
I hereby direct my attorney not to interfere with my claim or any lien upon, any medical payment benefit to which I may be entitled for either my health insurance, medical, workmen's compensation or other payments sources, and if any said medical payment checks which include my attorney's name, I direct my attorney to sign his name to these checks for the benefits of the medical provider, and Multicare Health Center.

_____ _____

Patient Witness

_____

Date