DIRECT PAYMENT AUTHORIZATION WITH

ASSIGNMENT OF BENEFITS

PATIENT NAME: _____

The undersigned hereby makes the following Acknowledgement and Agreement regarding the MRI/MRA and any other Professional Services to be provided to the patient whose name appears below.

This agreement allows me, the below named patient/insured, to be treated by HOMOSASSA OPEN MRI, INC. without paying for my care and treatment in advance. HOMOSASSA OPEN MRI, INC. will be paid within 30 days of submission of its claims for my care directly by my automobile insurance carrier providing Personal Injury Protection (PIP) benefits. This mutual consideration is considered good and sufficient by the parties.

I hereby guarantee full payment to the above companies and agree that I will remain personally responsible for any unpaid charges. I also grant the above companies a lien against my recovery which I any have now or in the future against any tortfeasor or any responsible insurance carrier. I promise to sign a letter of protection in favor of the HOMOSASSA OPEN MRI, INC. and I hereby direct that any attorney representing me now in the future execute a letter of protection in favor of the above companies.

I hereby assign and transfer to HOMOSASSA OPEN MRI, INC. all benefits, causes of action and rights to file a lawsuit that exist in my favor against any insurance company, including all automobile policies that provide no-Fault/PIP benefits, and I authorize you to prosecute said action either in my name or your name. it is understood that in consideration of this assignment, you will restrain form attempts and efforts to collect the amounts owed directly from me, until after reasonable efforts have been made to collect the sums due from the insurance company (or companies) contractually obligated, and I understand that whatever amounts you do not collect from insurance proceeds, I personally owe you, and agree to pay in a current manner. If any portion of this assignment is deemed inconsistent with F.S. 627.736, said portion shall be rewritten in order to conform with Florida law and to full effect to the intended purpose of this agreement.

I authorize and direct my present or future attorneys and my PIP automobile insurance carrier or carriers to release medical and legal information about me to the above companies.

_____ _____

Signature of Patient/Responsible party Date