HOPKINS CLINIC

6231 66th Street North   Pinellas Park, Florida 33781
Telephone 727 544 3330   Facsimile 727 544 3221
E mail address: hclinic@tampabay.rr.com   Website: www.hopkinsclinic.com

POWER OF ATTORNEY AND MEDICAL RELEASE

POWER OF ATTORNEY TO ENDORSE CHECKS AND/OR TO SIGN ANY PIECE OF PAPER WHICH WILL ENHANCE OR EXPEDITE PAYMENT TO PROVIDER FOR SERVICES RENDERED, INCLUDING BUT NOT LIMITED TO A RELEASE OF MEDICAL RECORDS and ASSIGNMENT OF BENEFITS/ AUTHORIZATION TO PAY.

Known by all these present that: The undersigned has made, constituted and appointed, and by these presents does hereby make, constitute and appoint HOPKINS CLINIC, and any of it's duly authorized agents and employees as and to be the undersigned's true and lawful attorney for the undersigned's name, place and stead to endorse any and all checks, drafts or money orders which are made payable to the undersigned alone or to the undersigned and the said HOPKINS CLINIC, which checks, drafts or money orders are made payable for services which have been made by HOPKINS CLINIC, at the request or with the knowledge and approval of the undersigned and/or the maker of the check, draft or money order.

Furthermore, the undersigned allows HOPKINS CLINIC, or any of its agents to sign any paper that will be necessary to enhance, expedite and/or allow payment to the said provider. This may include affidavits of non-ownership of vehicles, insurance forms and other statements.

The undersigned by these presents does give and grant the said HOPKINS CLINIC as attorney to the full power and authority to do and perform all and every act whatsoever requisite and necessary to be done in and about the premises as fully to all intents and purposes as the undersigned might or could do to personally present insofar as the endorsing and cashing of said checks are concerned as well as any other document.

MEDICAL RELEASE

A photocopy of this document shall be sufficient to authorize any person having records of medical treatment, services, or supplies pertaining to me to release true copies of the same to HOPKINS CLINIC or any insurer providing coverage to me in connection with the processing of any claim for the benefits made by me or by the assignee herein. A photocopy of this document shall be as binding as an original signature page.

The undersigned does hereby ratify and confirm any and all actions taken by the said attorney in accordance with this special power and which the said attorney shall do or cause to be done by virtue of these presents.

ASSIGNMENT OF BENEFITS

I, ____________________________________Hereby authorize____
(Name of Insured / Patient)   (Name of Insurance Carrier)
To make medical benefits payments otherwise payable to me for services rendered by HOPKINS CLINIC, but not to exceed the charges of those services, payable to and mailed directly to:

HOPKINS CLINIC FOR PHYSICAL MEDICINE
6231 66th STREET NORTH
PINELLAS PARK, FL 33781

Furthermore, I hereby IRREVOCABLY ASSIGN to HOPKINS CLINIC the rights and benefits and any causes of action under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statutes for any service provided by HOPKINS CLINIC and the charges therefore. Further, I hereby instruct the insurance carrier to request that, in the event the subject medical services and / or benefits are disputed for any reason, the amount of benefits being claimed by HOPKINS CLINIC are to be held in escrow and not to be disbursed until the dispute is resolved.

IN WITNESS WHEREOF the undersigned have hereunto set their hands, this_____ day of _____________, 200__.

_______________________________________   _________________________________
PATIENT'S SIGNATURE   PATIENT'S NAME (PLEASE PRINT)