AUTHORIZATION FOR REPAIR AND DIRECTION TO PAY

Customer name _____ **Phone** _____

Vehicle make & model _____ **Insurance Company** _____

Claim # _____ **Email** _____

Preferred Contact Method: **TEXT** ☐ **E-MAIL** ☐ **PHONE** ☐ **(Check One)**

REPAIR AUTHORIZATION

I DO HEREBY give USA AUTO COLLISION consent for repairs to be made to my vehicle and/or their subcontractors or designees, as set forth in the repair order or "Estimate of Repairs" dated _____ in the initial amount of $ _____ . I acknowledge receiving a written estimate of work to be done to my vehicle. I authorize the work to be done and for USA AUTO COLLISION to use parts, processes and materials that will be necessary to complete repairs. I authorize the shop to operate the vehicle for purposes of testing, performing calibration procedures and inspecting prior to delivery at my risk. The shop will NOT be held responsible for loss or damage to the vehicle or for articles left in the vehicle in case of fire, theft or accident or any other cause beyond the shops control. I understand that I am responsible for all charges, deductible amounts and or any balance due if not covered by the insurance company or other liable parties including me personally at the time of vehicle pickup.

ALL CHARGES MUST BE PAID IN FULL WHEN THE VEHICLE IS COMPLETED AND READY FOR PICKUP AND DELIVERY. Payment is to be made in full for the entire amount by insurance check, Money order, and cash or by credit card. We accept VISA, NASTERCARD, AMEX, or DISCOVER CARD (Personal checks are not accepted).

I also understand that:

1. Charges not covered by the insurance company are my responsibility, including but not limited to the following: Towing, Deductible, Betterments, or for additional work authorized by me.
2. An express mechanic's lien is hereby acknowledged to secure the cost of repairs to my vehicle in the event of non-payment by me.

DIRECTION TO PAY

The undersigned grants limited power of attorney to USA AUTO COLLISION for purposes of endorsing insurance checks in the event of co-pay insurance checks and or drafts are issued to the shop for repairs of the above identified vehicle.

SCAN CODE DIAGNOSTICS

I also understand that there will be scan code diagnostic procedures performed that are required by the vehicle manufacturer for purposes of identifying diagnostic codes in the vehicle's computer system. These are required steps in the repair process. My insurer may or may not recognize these as necessary. Due to this fact, this authorization recognizes the need and requirements for the shop to perform them on my behalf. It may necessary for me to pay for the scanning portion of the repair invoice and then submit that portion of the bill directly to my insurer for reimbursement. I recognize the fact that not completing the repair scans could result in serious injury or worse of occupants in my vehicle. INITIALS _____ DATE _____

CUSTOMER RIGHTS

I understand that:

I may request an estimate on the cost of repairs that exceed $ _____ in the state of Florida.

I may not be charged any amount over 10% of the written estimate without written or oral consent.

I am entitled to the return of any replaced parts except when parts are required to returned to the manufacturer under a warranty or core charge.

I may not be charged for repairs not originally authorized without written or oral consent.

SIGNATURE _____ **DATE** _____

ASSIGNMENT OF BENEFFITS, AUTHORIZATION TO SETTLE CLAIM AND DIRECTION TO PAY PROVIDER DIRECTLY

By my signature below, for good and valuable consideration (including but not limited to the extension of credit to me). I hereby assign, transfer and convey to:

USA AUTO COLLISION & GLASS (Here in after "the Provider") all of my rights, title and interest in and to auto repair reimbursement in whatever form, including but not limited to any insurance coverage under property damage, comprehensive, collision, windshield and/or any coverage otherwise payable to me through auto insurance. This payment shall not exceed my indebtedness owed by me to the assignee that is not otherwise satisfied by the above-mentioned assigned proceeds. I also acknowledge that any expenses not covered under my insurance policy will be my responsibility.

I further authorize the Provider to negotiate, collect and settle my claim with any insurance carrier or other third-party payer with regard to these services, which authorization shall include authority to:

(1) Request and receive from any insurer or any other party any and all documentation and records that I am empowered to request regarding this claim, including without limitation, a statement of coverage, policy declarations page and insurance policy. In addition, the provider has the authority to request and receive any documents that have been provided to me and,

(2) to endorse in my name any check issued for payment where benefits were assigned. By way of this assignment and notice, I further instruct you, the insurer, to finish Provider copies of all future notices affecting Provider's interest in this claim including, without limitation.

The Provider hereby objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protest, at the risk of insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full.

I further direct my insurer to direct all payments for services tendered by the Provider directly to Provider at the billing address contained in the Provider's repair bills.

THIS IS A DIRECT AND IRREVOCABLE ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER MY POLICY OF INSURANCE.

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

I have read de foregoing and understand and agree to each of the above provisions:

PRINT CLIENT

CLIENT'S SIGNATURE

DATE