

Assignment of My Benefits

IMPORTANT: All information must be **completed** or we will NOT be able to do the courtesy of dealing directly with your insurance plan.

1. Benefit Info

Patient portions are estimated and collected based on your insurance worksheet after verification with your insurance company(s). Professional Rehabilitation Services Physical Therapy bills for its services, however, at one standard fee to all payors. For each code rate adjustments are not applied until after the receipt of an explanation of benefits from your insurance company. Upon receipt of an insurance explanation of benefits, the patient's portion is finalized and patient pre-payments are applied accordingly. Refunds are not issued until all insurance processing is finalized.

2. Policy Info

- All information must be filled out to file insurance

Primary Insurance Name _____

ID Number _____ Group # _____

Secondary Insurance Name _____

ID Number _____ Group # _____

I hereby instruct and direct my insurance company(s) : _____

to pay by check made out to the "Healthcare Provider" to the right and mailed to the address on the right (not mine). If my/this current policy prohibits direct payment to doctor/therapist, I hereby also instruct and direct you to make out the check to me and mail it to the address on the right (not mine) for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered.

| |
|-------------------------------|
| Subscriber Info |
| Name: _____ |
| Date of Birth: ____/____/____ |
| Relationship: _____ |

| |
|-------------------------------|
| Subscriber Info |
| Name: _____ |
| Date of Birth: ____/____/____ |
| Relationship: _____ |

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|---|
| Healthcare Provider info: |
| Professional Rehabilitation Services |
| P.O. Box 2397 |
| Pawleys Island, SC 29585 |

This is a direct assignment of my rights and benefits under this policy.

This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

(Check each box and sign at the bottom)

- A photocopy of this Assignment shall be considered as effective and valid as the original.
- I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment of benefits.
- I authorize the use of this signature on all insurance submissions.
- I authorize the "Healthcare Provider" named above to deposit checks made in my name.
- I authorize the "Healthcare Provider" named above to initiate a complaint to the Insurance Commissioner for any reason on my behalf.
- I understand that I am financially responsible for all charges whether or not paid by insurance.

Dated this _____ day of _____, 20____

Signature of Policyholder

Witness

Signature of Claimant, if other than Policyholder