

Re**Quest** Physical Therapy

INSURANCE ASSIGNMENT AGREEMENT AND AUTHORIZATION TO RELEASE INFORMATION

RELEASE OF INFORMATION I, the below named patient, hereby authorize ReQuest Physical Therapy to release to any third party payer (such as an insurance company or governmental agency, example: Blue Cross of Florida or Medicare) any medical condition and records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for payment for such treatment and/or diagnosis.

THERAPIST/CENTER INSURANCE ASSIGNMENT I, the below named patient, hereby authorize payment directly to ReQuest Physical Therapy and/or any therapist examining or treating me for any group and/or individual medical benefits herein specified and otherwise payable to me for their services as described but not to exceed the reasonable and customary charge for these services. I understand and agree that the center providing services is based on a treatment team approach to care. The treatment team consists of physical therapists, physical therapist assistants, licensed massage therapists, exercise specialists, athletic trainers and interns in training working under the direction and supervision of the treating physical therapist.

MEDICARE PATIENT'S CERTIFICATION AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST I, the below named patient, certify that the information given by me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to Social Security Administration\Division of Family Services or its intermediaries or carriers any information needed for this or a related Medicare claim. I hereby certify all insurance pertaining to treatment shall be assigned to the center/therapist treating me.

MY RESPONSIBILITY I, the below named patient, understand it is my responsibility to pay at time of service any deductible amount, co-payment, co-insurance or any other balance not paid for by my insurance. If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.

I PERMIT A COPY OF THESE AUTHORIZATIONS AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL, WHICH IS ON FILE AT REQUEST PHYSICAL THERPY. This assignment will remain in effect until revoked by me in writing.

Patient Name (please print) _____

Patient / Guardian Signature _____ Date _____