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.

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1. Benefit Info

What is your deductible amount? $ 0.00 and coinsurance % 0.00 (for the services you are seeking)

Are there any maximums? ○ Yes ○ No

If you don't know this information, call the "800" number on your insurance card. The front desk person may be able assist you.

2. Policy Info

Patient Name ert retert ID 676-5 DOB 04/12/2000

Insurance Policy 1 Name/Number/Group # (if applicable)

ert retert/ 65765/ 657657

****IS PATIENT INSURED THROUGH SOMEONE ELSE'S POLICY?**

Give their info here: (otherwise, skip this portion)

Policyholder Name ert retert Date of Birth 11/15/2017

SSN

Address (if different than Patient)

Relationship to Patient: ○ Spouse ○ Parent ○ Other

Employer Ph#

Claim #

Employer Address

, , , ,

Insurance Policy 2 Name/Number/Group # (if applicable)

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I hereby instruct and direct _____ insurance company 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 above address 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.

Healthcare Provider info:

Advanced Physical Therapy of Central Florida
303 SE 17th Street, #209-229
Ocala, Florida 34471

PH: (352) 693-3378

This is the 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, oe attorney involved in this case for the purpose of processing claims and securing payment of benefits.

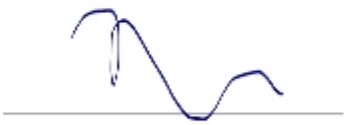
☑ I authorize the use of this signature on all insurance submissions.

☑ 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 the charges whether or not paid by insurance.

Alternate Text



Signature of Policyholder

Witness

Signature of Claimant, if other than Policyholder

11/15/2017 4:48:50 PM
Date

11/15/2017 4:48:56 PM
Date

Date