Assignment of Benefits Form

Name of Insured (print):_____

Date of birth:_____

□ _____ is my primary insurance

□ _____ is my secondary insurance (leave blank if none)

I request the payment of authorized insurance benefits (including Medicare, if I am a Medicare beneficiary) to be made on my behalf to The Healing Institute of Physical Therapy (the "Provider") for any services provided to me by the Provider. I authorize the release of any medical or other information necessary to determine the extent of all benefits payable for related equipment or services on my behalf to the (i) the Provider, (ii) the Centers for Medicare and Medicaid Services ("CMS"), (iii) my insurance carrier, (iv) or other medical entity. A copy of this authorization will be sent to CMS, my insurance company, or other entity if requested. The original authorization will be kept on file by the Provider. I understand that this assignment will remain in effect until revoked in writing by me.

I understand that I am financially responsible to the Provider for any charges not covered by health insurance benefits. It is my responsibility to notify the Provider of any changes in my health insurance coverage.

If I am a Medicare beneficiary, I understand that Medicare does not pay for maintenance treatments and that I am responsible for paying for these services out-of-pocket. I also authorize payment of all medical benefits to apply to all occasions for primary and supplemental (Medigap) coverage to be paid to the Provider.

In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the Provider and/or my healthcare insurer if the submitted claims or part of them are denied for payment.

I understand that, by signing this form, I am accepting financial responsibility, as explained above, for all payment and services provided by the Provider. By signing this document, I also acknowledge that I have reviewed the Provider's Notice of Privacy Practices. This acknowledgment is required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my rights.

Print name of person signing below:_____

Signature of insured or parent/guardian:_____

Date:_____