# SIGNATURE ON FILE & INSURANCE ASSIGNMENT

I hereby authorize Center for Physical Therapy to file insurance claims on my behalf and to furnish any and all records pertaining to medical history, services rendered or treatment given to me or my dependants for purposes of review, investigation or evaluation of my insurance claims. If my coverage is under a group contract held by my employer, an association, trust fund, union or similar entity, this authorization permits disclosure to them for purposes of utilization review or financial audit. If my insurance policy allows, I hereby "assign" or "authorize" direct payment to Center for Physical Therapy toward any physical therapy services performed. This authorization shall become effective immediately and shall be valid until rescinded in writing or replaced by one of a later date. A photostatic copy of this authorization shall be considered as effective and valid as the original.

_____ _____

*Patient Name: First Middle Last* *Patient's Age*

_____ _____

*Patient Signature* *Date*

_____ _____

*Parent or Legal Guardian Name* *Relationship to patient*

_____ _____

*Parent or Legal Guardian Signature* *Date*

I hereby authorize and request my insurance company to pay directly to Center for Physical Therapy the amount(s) due to my claim for services rendered to me or my dependant. I further agree that should the amount be insufficient to cover the entire medical expense, I will be responsible for payment of the difference; and if the nature of the disability be such that it is not covered by the policy, I will be responsible to the Center for Physical Therapy for payment of the entire bill. If previous arrangements have not been made with our billing department, any account balance outstanding greater than 90 days with no monthly payments made will be forwarded to a collection agency. Accounts placed with a collections agency will incur all collections fees.

_____ _____

*Patient Signature* *Date*

_____ _____

*Insured Signature* *Date*

**If patient is younger than 21 years of age, please complete the following information regarding the person legally responsible for paying these medical bills:**

_____ _____

*Name of Responsible Party* *Social Security Number*

_____ _____

*Responsible Party Signature* *Date*

_____

*Mailing Address*

_____ _____ _____ _____

*City* *State* *Zip* *Phone Number*