CENTRAL PHYSICAL THERAPY ASSIGNMENT of BENEFITS FORM

I hereby authorize the payment of medical benefits directly to CENTRAL PHYSICAL THERAPY, LLC for services rendered. I further authorize the release of health care information provided by the physical therapist to my insurance company or their agents for the purposes of administering claims for benefits. I agree that I am financially responsible for all balances not paid by my insurance company. Benefit information obtained by CENTRAL PHYSICAL THERAPY, LLC as a courtesy is not a guarantee of benefits or payment. The patient is encouraged to contact their insurance company to obtain benefit information themselves. Billing is kept in house at this time. This process can take up to 60 days to reconcile with your insurance company. Please be aware you are incurring expenses during your treatment and you are responsible for those fees. We ask that any portion that is your responsibility be paid in full within 60 days of your last appointment with us. Other arrangements can be made with the owners or office manager if necessary.

_____ _____
Insurance Carrier NAME Subscriber ID#/ Cert. #

_____ _____
Insurance Company PHONE Group #

_____ _____
Subscriber's EMPLOYER Patient's EMPLOYER IS

_____ _____
Subscriber/Policy holders NAME Subscriber/Policy holders DATE OF BIRTH

_____ _____
Subscriber's EMPLOYER Patient's EMPLOYER IS

THIS A COBRA PLAN? (Please circle) YES / NO

#_____NUMBER OF PHYSICAL THERAPY, OCCUPATIONAL THERAPY and CHRIROPRACTIC THERAPY USED AT ANOTHER OFFICE THIS BENEFIT YEAR?

X_____ x_____
Patient or Parent of Minor SIGNATURE DATE

AUTO ACCIDENT? (Please circle) YES / NO DATE OF AUTO ACCIDENT_____

_____ _____
AUTO Insurance company NAME PHONE #

_____
AUTO Insurance ADDRESS

_____
Adjustor/Contact NAME

IF THERE IS ANY POSSIBILITY THAT YOUR INJURY IS WORK RELATED PLEASE ASK TO SPEAK TO THE OFFICE MANAGER NOW!!!