BALANCED REHAB
PHYSICAL THERAPY

Insurance Billing

Patient: _____ Date: _____

Employer: _____ Claim Group: _____

Social Security # or ID #: _____

I hereby instruct and direct _____ Insurance Company to pay by check made out and mailed to Balanced Rehab, 160 S. Beach St., Daytona Beach, FL 32114.

OR

If my current policy prohibits payments to Balanced Rehab, I hereby also instruct and direct you to make out the check to me and mail it as follows: Balanced Rehab 160 S. Beach Street, Daytona Beach, FL 32114 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. THIS IS A 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.

A photocopy of this Agreement shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize Balanced Rehab to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Dated in Volusia County, Florida, this _____ day of _____, 20___.

_____ _____

Signature of Policyholder Witness

_____

Signature of Claimant if other than Policyholder