Orthopedic and Sports Physical Therapy

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Assignment of Benefits Form

Patient: _____ Date:_____

ID #: _____ Group #: _____

I, _____, understand that services rendered to me by PRO PT is my financial responsibility and that PRO PT will bill my insurance company, _____ as a courtesy. I authorize my insurance
(Insurance company name)
company to pay my benefits directly to PRO PT and I understand that I will be fully responsible for any outstanding balance on my account.

I have been given the opportunity to pay my estimated deductible and co-insurance at the time of service. I have chosen to assign the benefits, knowing that the claim must be paid within all state or federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the prompt payment of the claim by my insurance company.

I authorize PRO PT to release any information necessary to adjudicate the claim, and understand that there may be associated costs for providing information above and beyond what is necessary for the adjudication of a clean claim.

I also understand that should my insurance company send payment to me, I will forward the payment to PRO PT within 48 hours. I agree that if I fail to send the payment to PRO PT and they are forced to proceed with the collections process; I will be responsible for any cost incurred by the office to retrieve their monies.

I also understand that in the event that my insurance company fails to pay or were to retract payment from PRO PT for any reason, I am fully responsible for any and all outstanding payments due.

I authorize PRO PT to initiate a complaint to the insurance commissioner for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials.

_____ _____

Signature of Policyholder Patient /Guardian Printed Name