

Sport & Spine Physical Therapy and Wellness Center

15303 Amberly Drive, Suite C, Tampa, FL 33647
Phone: (813)699-9040 Fax: (813)699-9040

Assignment of Benefits

Patient Name: _____ Date of Birth: _____
Insurance Name: _____ Policy Type: HMO PPO EPO Auto WC
Policy ID: _____ Group #: _____ Claim #: _____
Primary Insured: _____ Date of Birth: _____
Relationship to Patient: Parent Spouse Other _____

I hereby instruct and direct the above listed insurance company to pay by check made out and mailed to:

**Sport & Spine Physical Therapy and Wellness Center
15303 Amberly Drive, Ste. C
Jensen Beach, FL 33647**

If my/this current policy prohibits direct payment to the doctor/facility, I hereby also instruct and direct you to make out the check to me and **mail it to the above address** 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.

This is a direct assignment of my right and benefits under this policy.

This payment will not exceed my indebtedness to the above mentioned assignee, and I have to agree to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

(Check each box and sign at the bottom)

- A photocopy of this Assignment shall be considered as effective and valid as the original.
- I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment of benefits.
- I authorize the use of this signature on all insurance submissions.
- I authorize *Sport & Spine Physical Therapy and Wellness Center* to deposit checks made in my name.
- I authorize *Sport & Spine Physical Therapy and Wellness Center* to initiate a complaint to the Insurance Commissioner for any reason on my behalf.
- I understand that I am financially responsible for all charges whether or not paid by insurance.

I have read and fully understand the information listed above, and to the best of my knowledge, all information is accurate.

Patient/Guardian Name (Print)

Patient/Guardian Signature

Date