Generations R.C., Inc.
dba/Generations Physical Therapy

We need authorization to bill your insurance company rather than billing you directly. This form provides that permission.

In case of personal injury litigation or motor vehicle accident litigation, we also need a Letter of Protection by your attorney. If we have no Letter of Protection from your attorney some state laws regarding subrogation require that we must bill you directly and therefore we must have full payment at the time of each office visit.

ASSIGNMENT OF INSURANCE BENEFITS AND STATEMENT OF SERVICE

I hereby authorize and assign payment made directly to Generations, R.C., Inc., of the covered insurance benefits, including major medical benefits, whether payable to me by Blue Cross Blue Shield, Medicare, Worker's Compensation, and/or commercial insurance companies. I understand that my health insurance provider may not cover part or all of the medical services rendered, and I fully understand that I am financially responsible for and agree to pay all charges not paid by my health care coverage, including deductibles, coinsurance, and payments from insurance companies sent directly to me.

This assignment shall apply to all medical services now rendered and to be rendered in the future until this authorization and assignment is revoked.

I have listed below the names of all my health insurance providers including tie-in coverage and I represent that such health care coverage is in full force and effect at this time.

If prior authorization or certification for medical services is required under my health care coverage, I agree to obtain and furnish such authorization or certification.

I authorization the release of medical information as may be required to process the claims for payment of the medical services rendered and it is expressly understood that the right of such information to be privileged is hereby waived.

I agree to promptly notify your office of any changes of address, phone number or insurance carrier.

A copy of this assignment shall be considered as valid as the original.

X _____ X _____

Signature of Patient or Guardian Date Signature of Policy Subscriber Date

Social Security Number _____ Social Security Number _____

Employer-Firm _____ Employer-Firm _____

Insurance Company _____ Insurance Company _____

Certificate or Policy # _____ Certificate or Policy # _____

Group/Individual _____ Medicare Number (if applicable) _____