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

This is the supplement to the form that allows us to bill your insurance company or personal injury case.

ASSIGNMENT, LIEN AND AUTHORIZATION re: INSURANCE BENEFITS AND ATTORNEY

To Whom It May Concern:

I hereby authorize and direct you, my insurance company and/or my attorney, to pay directly to Generations R.C., Inc., such sums as may be due and owing this office for services rendered me, both by reason of accident or illness and by reason of any other bills that are due this office and to withhold such sums from any disability benefits, medical payment benefits, no-Fault benefits, health and accident benefits, Worker's Compensation benefits or any other insurance benefits obligated to reimburse me or from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect said office such sums as may be due and owing this office for services rendered me. I hereby further give a lien to said office against any and all insurance benefits named herein of the injuries or illness for which I have been treated by said office. This is to act as an assignment of my rights and benefits to the extent of the office's services provided.

In the event that the insurance company obligated to make payment to me upon the charges made by this office for their services refuses to make such payment, upon demand by me or in this office, I hereby assign and transfer to this office any and all causes of action that I might have or that might exist in my favor against such company and authorize this office to prosecute said cause of action either in my name or in the office's name and further if authorize this office to compromise, settle or otherwise resolve said claim or cause of action as they see fit.

I understand that I remain personally responsible for the total amounts due the office for their services. I further understand and agree that this Assignment, Lien, and Authorization do not constitute any consideration for the office to await payment and they may demand payments from me immediately upon rendering services at their option.

I authorize the office to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under the Assignment, Lien, and Authorization. I agree that the above-mentioned office be given power of Attorney to endorse/sign my name on all checks for payment of my therapist bill.

I further understand and agree, that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment of and will reimburse this office for all cost of such collection efforts, including but not limited to all court cost and all attorney fees.

Patient: _____ Date: _____

Witness: _____ Date: _____