

Assignment Of My Benefits

For PPS, POS, Medicare, Medicaid, Med-Pay, PIP, Lien, and Private Third Party Payers

1. Benefits Info

If you have a co-insurance, co-payment, or *unmet* deductible please notify front desk or billing personnel. We will need a copy of **any** insurance information you have as well as your driver's license or identification card. Benefits will be verified between our office and your insurance however, as stated by most insurance policies, "*a verification of benefits is not a guarantee of payment*". ***Payment (if self paying), co-payment, or deductible payment is due at time of each visit.**

2. Policy Info

I hereby instruct and direct my insurance company, attorney, and/or person(s) responsible for services render to me to pay by check made out and mailed to:

Pro Motion Rehab, Inc. 1787 W. US Hwy 64 Suite #3 Murphy, N.C. 28906
Office: 828-837-0400 Fax: 828-837-0404 Email: pt@promotionrehab.com

If my/this current policy prohibits direct payment to above company, 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 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 not paid by my insurance (co-pays, deductible, or denial).

(Sign and date this document at the bottom)

A photocopy or fax copy 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 directly 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 Pro Motion Rehab, Inc. to deposit insurance checks made in my name for their services.

I authorize Pro Motion Rehab, Inc. to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

I understand that I am ultimately financially responsible for the services I receive whether or not paid by my insurance.

***Note: Providers may not bill any patient more than has been allowed by the insurance company with which they contract.**

NOTE: We accept cases of personal injury where fault is or is NOT determined. We usually do **request payment be made at the time of service even in cases where an attorney is involved. In certain cases we may defer payment until the cases settles, however, a **lien agreement** will be required to secure payment. We **do not charge any fees** for this service even though we may not receive payment for work provided for 12-24 months so please be informed that we **do not accept "discounted settlements"** and we will not change to your private insurance after you have been discharged unless your case has settled and no money had been awarded. We do offer an **incentive program** to certain attorneys that refer potential patients and for accounts paid in a timely manner. We do ask that the patient understand **all** amounts are due and payable by them or their guardian/parent in the event the patient is a minor, and that **the patient or guardian/parent is responsible for all charges** regardless of the outcome of the case.**

Please note that any documentation requests and/or deposition appearance requests by an attorney or yourself will incur additional fees. We do not accept all cases and reserve the right to refuse service to anyone.

Dated this _____ day of _____ 20_____.

Signature of Policyholder

Witness

Signature of Claimant,
if other than Policyholder