

Balance Diagnostics and Balance & Neuro Physical Therapy

Assignment of Benefits & Authorization to Release Information

In consideration of services rendered, I hereby transfer and assign to Balance & Neuro PT all rights, title and interest in any payment due me for services described herein as provided in the stated policy or policies of insurance.

I further assign all rights to payment due for medical services under said policies to Balance & Neuro PT and that I am financially responsible for the medical services provided should my insurance not pay as previously indicated.

I authorize Balance & Neuro PT to release medical information about me as may be necessary for the completion of my insurance claims for this occasion of services to any insurance carrier.

I understand and agree that it is my responsibility to inform Balance Diagnostic and Balance Physical Therapy of any changes to my insurance coverage, employer, or demographic information at the time of each office visit. Any charges that occur as a result of my failure to provide this needed information will be my responsibility.

Balance Diagnostic and Balance Physical Therapy may leave messages related to my therapy on (____) ____ - _____ & may give personal information to the following family member _____.

Signature of patient, patient's agent or representative

Date

Signature of Witness From BNPT/BDMC Staff

Date
