ASSIGNMENT of BENEFITS

I hereby authorize the payment of medical benefits directly to BACKtoGOLF PERFORMANCE & FITNESS Inc. for services rendered. I further authorize the release of health care information provided by the physical therapist to my insurance company or their agents for the purposes of administering claims for benefits. I agree that I am financially responsible for all balances not paid by my insurance company.

Benefit information obtained by BACKtoGOLF as a courtesy is not a guarantee of benefits or payment. The patient is encouraged to contact their insurance company to obtain benefit information themselves.

Billing is kept in house at this time. This process can take up to 60 days to reconcile with your insurance company. Please be aware you are incurring expenses during your treatment and you are responsible for those fees. We ask that any portion that is your responsibility be paid in full within 60 days of your last appointment with us. Other arrangements can be made with the owners or office manager if necessary.

_____ _____

Insurance Carrier NAME | Subscriber ID#/ Cert. #

_____ _____

Insurance Company PHONE | Group #

_____ _____

Subscriber/Policy holders NAME | Subscriber/Policy holders DATE OF BIRTH

_____ _____

Subscriber's EMPLOYER | Patient's EMPLOYER

IS THIS A COBRA PLAN? (Please circle) YES NO

#_____ NUMBER OF PHYSICAL THERAPY, OCCUPATIONAL THERAPY, CHRIROPRACTIC THERAPY USED ELSEWHERE AT ANOTHER OFFICE THIS BENEFIT YEAR?

X_____ **x**_____

Patient or Parent of Minor SIGNATURE | DATE

AUTO ACCIDENT? (Please circle) YES NO DATE OF AUTO ACCIDENT_____

_____ _____

AUTO Insurance company NAME | PHONE

_____ _____

AUTO Insurance ADDRESS | Adjustor/Contact NAME

IF THERE IS ANY POSSIBILITY THAT IS WORK RELATED PLEASE ASK TO SPEAK TO THE OFFICE MANAGER NOW !!!

06202007 assgnbenpi