



Advantage Physical Therapy
and Rehabilitation, LLC

NOTICE OF ASSIGNMENT OF BENEFITS

An assignment of benefits is an arrangement by which a patient requests that the insurance company benefit payments be made directly to a designated person or facility, such as a physician or hospital.

INSURANCE AUTHORIZATION AND ASSIGNMENT OF BENEFITS

Please be advised that the patient's signature or, in the case of a minor or mentally handicapped individual, the signature of a parent or legal guardian, absolutely provides for the assignment of benefits to *Advantage Physical Therapy and Rehabilitation, LLC*, authorizing payment in full be made directly to the healthcare provider, *Advantage Physical Therapy and Rehabilitation, LLC*.

I, (Fill in Name) _____, hereby absolutely authorize *Advantage Physical Therapy and Rehabilitation, LLC* to apply for benefits on my behalf for services rendered to me or my dependents(s) and request that payment be sent directly to *Advantage Physical Therapy and Rehabilitation, LLC*.

I certify that I have provided *Advantage Physical Therapy and Rehabilitation, LLC* with all necessary information regarding my open claim with (Fill in Insurance Company Name) _____. Failure to provide updates to any of the information supplied within may result in denial of payment to *Advantage Physical Therapy and Rehabilitation, LLC*. I understand that it will be my responsibility to pay *Advantage Physical Therapy and Rehabilitation, LLC* medical practice for those medical services rendered to me or my dependent(s). I understand that I am financially responsible for all charges whether or not paid by insurance.

I certify that the information I have reported with regard to insurance coverage is correct and I hereby authorize *Advantage Physical Therapy and Rehabilitation, LLC*, the release of any information relating to any claim for benefits, in order to process any claim for benefits and to secure the payment of benefits. Furthermore, I permit a copy of this authorization to be used in place of the original.

Signed: _____ Date: _____

Print Name: _____

Witnessed Signature: _____ Date: _____

Witness Printed Name: _____

Insurance Co: _____ Claim No: _____

Date of Injury: _____ Adjustor: _____ Phone: _____

7560 Gardner Park Dr, Gainesville, VA 20155
(703) 753-1005 Phone (703) 753-2207 Fax

9161 Liberia Ave, Ste 205, Manassas, VA 20110
(571) 229-1111 Phone (571) 229-1112 Fax