

# Assignment of Benefits to Back In Motion, Sarasota Physical Therapy

Patient Name: \_\_\_\_\_

Insurance Policy #: \_\_\_\_\_

Insured Name: \_\_\_\_\_ Insured Date of Birth \_\_\_\_\_

Your relationship to the Insured:  Self  Spouse  Other: \_\_\_\_\_

Claim # (if applicable): \_\_\_\_\_

I hereby instruct and direct \_\_\_\_\_ insurance company to pay by check made out and mailed to:

**Back In Motion, Sarasota Physical Therapy**  
**3920 Bee Ridge Road, Bldg E, Unit G**  
**Sarasota, FL 34233**  
**Ph) 941-925-2700 Fax) 941-925-7744**

If my/this current policy prohibits direct payment to doctor, 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 over and above this insurance payment.

**\*(Check each box and sign at the bottom)- ALL BOXES MUST BE CHECKED OFF.**

- A photocopy 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 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 Back In Motion to deposit checks made in my name.
- I authorize Back In Motion to initiate a complaint to the Insurance Commissioner for any reason on my behalf.
- I understand that I am financially responsible for all charges whether or not paid by insurance.
- I understand that a service charge will be assessed to my account if a Second and Third notice has to be sent to me for a past due balance. All accounts that are past 90 days over due will be sent to a Collection Agency.

**Additional Information for Medicare Beneficiaries: Check box if a Supplemental Policy will be utilized.**

- I understand that Back In Motion will file claims to my Medicare Supplement Policy as a courtesy, but I am solely responsible for verifying that Physical Therapy is a covered benefit under my Supplemental Plan. *(Coverage & Eligibility can be determined by contacting your insurance provider via telephone or consulting your plan booklet).*

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Signature of Policyholder

\_\_\_\_\_  
Signature of Claimant, if other than Policyholder