PRIMARY INSURANCE ☐ MEDICARE ☐ OTHER _____	PRIMARY INSURANCE ID #	PRIMARY INS PHONE # (IF OTHER THAN MEDICARE)
PRIMARY INSURANCE CLAIMS ADDRESS (IF OTHER THAN MEDICARE)		
SECONDARY INSURANCE	SEC INSURANCE ID #	SEC INSURANCE PHONE #
SECONDARY INSURANCE CLAIMS ADDRESS		
IF PATIENT IS NOT THE INSURANCE SUBSCRIBER: SUBSRIBER NAME DATE OF BIRTH		

ASSIGNMENT OF MY INSURANCE BENEFITS TO PAINFREE PHYSICAL THERAPY INC

I hereby instruct and direct my insurance company to pay by check payable and mailed to Painfree Physical Therapy Inc, 9625 Water Fern Circle, Clermont, FL 34711. 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 Painfree Physical Therapy Inc, 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)

☐ 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 Painfree Physical Therapy Inc to deposit checks made in my name.
☐ I authorize Painfree Physical Therapy Inc 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.

SIGNATURE OF POLICYHOLDER / CLAIMANT / RESPONSIBLE PARTY	DATE