Authorization and Assignment of Benefits

I, hereby authorize Klaff Sports Physical Therapy, Inc to apply for benefits from my insurance carrier(s) listed and further authorize payment directly to, Klaff Sports Physical Therapy, Inc of the medical benefits, if any, otherwise payable to me for services rendered by Klaff Sports Physical Therapy, Inc.

Medicare Only: I request that payment of authorized Medicare benefits be made either to me or on my behalf to Klaff Sports Physical Therapy, Inc for my services furnished to me by Klaff Sports Physical Therapy, Inc. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

I hereby authorize Klaff Sports Physical Therapy, Inc to administer any treatment as may be deemed necessary or advisable in the diagnosis and treatment of ________________________________ (patient). Further, I authorize Klaff Sports Physical Therapy, Inc to any collateral source in the case of Medicare, the Social Security Administration and the Health Care Financing Administration that will pay part or all of said medical bills. I hereby waive on my behalf of myself and any persons who may have an interest in the matter all provisions of law relating to disclosure of confidential medical information.

I understand that all bills for services are due from me when rendered, and I am completely responsible for these charges regardless of any third-party interest, payer or the resolution of any legal action or lawsuits in which I may be involved. I further understand that Klaff Sports Physical Therapy, Inc reserves the right to pursue delinquent accounts via third-party collection agencies or attorneys. In the even my bill is referred to collection, I agree to pay all collection fees, the pre-judgment interest of 18%, reasonable attorney fees, court costs and services of process costs to physical therapist in addition to the amount owed for the services rendered. This agreement is a contract under seal and shall be considered a specialty.

Estimated Portion Due from Patient:_____________________________________

This Authorization and Assignment of Benefits is valid for all episodes of care rendered by any and all physical therapists and/or physical therapist assistants associated with Klaff Sports Physical Therapy, Inc.

Witness my hand and seal this _________ day of______________,_____________

X ____(Seal) ____

Signature of Patient or Guardian, if Minor | Relationship to Patient

____ ____

(Printed Name) of Patient or Guardian | Witness