

**ASSIGNMENT OF BENEFITS, AUTHORIZATION TO SETTLE CLAIM
AND DIRECTION TO PAY MEDICAL PROVIDER DIRECTLY**

Patient: _____

Insured: _____

Insurance Co: _____

Claim #: _____

By my signature below, for good and valuable consideration (including but not limited to the extension of credit to me), I hereby assign, transfer and convey to:

SOUTH FLORIDA PHYSICAL THERAPY ASSOCIATES

(hereinafter "the Provider") all of my rights, title and interest in and to medical expense reimbursement in whatever form, including but not limited to any automobile liability medical expense payments or other health benefits indemnification and/or agreement otherwise payable to me. This payment shall not exceed my indebtedness to the above named assignee and I acknowledge that I will timely pay any indebtedness owed by me to the assignee that is not otherwise satisfied by the above-mentioned assigned proceeds. I also acknowledge that any medical expenses not covered under my insurance policy will be my responsibility.

I further authorize the Provider to negotiate, collect and settle any claim with any insurance carrier or other third party payor with regard to these services, which authorization shall include authority to: 1) request and receive from any insurer or any other party any and all documentation and records that I am empowered to request regarding this claim, including, without limitation, any Independent Medical Examination Reports, Records Review Reports, Explanations of Benefits, and Benefit Payment Sheets or Logs (P.I.P. Payout Sheets), without regard as to whether such documentation has already been provided to me and 2) to endorse in my name any check issued for payment where benefits were assigned.

I further direct my insurer to direct all payments for services rendered by the Provider to:

SOUTH FLORIDA PHYSICAL THERAPY ASSOCIATES

THIS IS A DIRECT AND IRREVOCABLE ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER MY POLICY OF INSURANCE.

A photocopy of this form shall be considered as effective and valid as the original.

I have read the foregoing and understand and agree to each of the above provisions:

Patient's signature

Date