

ASSIGNMENT OF MEDICAL BENEFITS, PAYMENT RESPONSIBILITY AND AUTHORIZATION FOR TREATMENT

PATIENT: _____

1. THE UNDERSIGNED, hereby authorize Outbound Physical Therapy & Rehab and its affiliates (“Provider”) to render to Patient physical therapy, occupational therapy, speech therapy or other related services (collectively, “Therapy Services”) that Provider or Patient’s treating physician determines may be necessary or advisable. Patient agrees to cooperate with all reasonable requests by Provider in connection with Provider’s rendition of Therapy Services.
2. THE UNDERSIGNED, hereby certify that all information provided to Provider by the undersigned or Patient, including any information in connection with applying for a payment under Title XVIII of the Social Security Act, is true and accurate in all respects.
3. THE UNDERSIGNED, hereby authorize Provider to disclose any information, furnished to Provider or obtained by provider in connection with Patient’s treatment (including information concerning a related Medicare claim), to any physician, governmental agency (including the Social Security Administration or any of its intermediaries or carriers), insurance company or health care facility requesting such information.
4. THE UNDERSIGNED, hereby assign to Provider all Medicare benefits and Medicaid benefits to which Patient may be entitled for any Therapy Services rendered by Provider. The undersigned hereby authorize and direct Provider to apply and file for all such benefits on behalf of Patient. In the event Patient is covered by both Medicare and Medicaid, Patient’s Medicare deductible and any applicable Medicare co-payment will be covered by Medicaid. The undersigned acknowledge that Provider has disclosed to the undersigned that Provider is a supplemental Medicaid provider and that Provider is paid directly by Medicaid. In addition, the undersigned approves contact with the appropriate family members for medical claims management purposes.
5. THE UNDERSIGNED, hereby assign to Provider all private medical insurance benefits (primary and secondary, including med. Gap providers) or other benefits to which Patient may be entitled for any Therapy Services rendered by Provider. The undersigned hereby authorize and direct provider to apply and file for all such benefits on behalf of Patient.
6. THE UNDERSIGNED, authorizes Outbound Physical Therapy & Rehab to deposit checks received on Patient’s account when made out to the patient or signed over by the patient when Insurance Company pays against services provided.
7. THE UNDERSIGNED, agree that the undersigned shall be jointly and severally financially responsible for any portion of Provider’s invoice that is not paid, except in the event of Medicare denial or Medicaid eligible recipients. The undersigned warrant and represent to Provider that Patient is not a member of, or covered by, a health maintenance organization or similar arrangement. The undersigned shall be liable to Provider for all services rendered by Provider in the event Patient is covered by a health maintenance organization or similar arrangement.

1739 Elm Ct. Ste 205/206 Jefferson City, MO 65101 PHONE 573-681-0447 FAX 573-681-0445

3600 Country Club Dr Suite 530B Jefferson City, MO 65109 PHONE 573-606-7100 FAX 573-681-0445



8. THE UNDERSIGNED and patient agree to execute any documents and perform any acts that Provider may reasonably request. The undersigned warrant and represent that attached hereto are originals or certified copies of any applicable powers of attorney, health care surrogate forms or court orders appointing the undersigned as the legal guardian of Patient.

9. THE UNDERSIGNED, agree that the provisions hereof shall continue in full force and effect until Provider has received written notice of termination signed by the undersigned; provided, however, that the provision of paragraphs 2, 4, 5, and 6 shall survive any such termination.

10. THE UNDERSIGNED, acknowledge that Provider has disclosed to the undersigned that no physician owns any interest to Provider.

11. THE UNDERSIGNED understands that they have a choice or rehabilitation service providers.

Patient's Signature/Legal Representative

Date

Practice Representative

Date