TheraPhysical
623 Ridge Road Lyndhurst NJ 07071 T 201 340 4656 F 201 340 4580 info@theraphysical.com
www.theraphysical.com

ASSIGNMENT OF RIGHTS AND BENEFITS

I irrevocably assign to TheraPhysical, all my rights and benefits under any insurance contracts for payment for services rendered to me by TheraPhysical. I irrevocably authorize all information regarding my benefits under any insurance policy relating to any claim by TheraPhysical to be released to TheraPhysical. I irrevocably authorize TheraPhysical to file insurance claim on my behalf for services rendered to me. I irrevocably direct that all such payments go directly to TheraPhysical. I irrevocably authorize TheraPhysical to act in my behalf and report any suspected violations of proper claims practices to the proper regulatory authorities.

I irrevocably authorize TheraPhysical to obtain counsel and enter legal or other action on my behalf and /or my name; including the arbitration/ dispute resolution process, to collect such sums due it should sum not be paid within the legally prescribed time frame. In the event that TheraPhysical elect to bring a lawsuit of petition for arbitration/dispute resolution their claim for any unpaid bills for services rendered for injuries that I sustained in this or any accident.

In the event that this assignment is held invalid for any reason, I hereby authorize TheraPhysical to appoint an attorney of its choice to represent me directly against an insurer from which I may collect PIP benefits and to bring a claim in a forum of its choice. This appointment is intended on enabling the attorney to collect the bills of TheraPhysical.

The undersigned patient does hereby agree and acknowledge that he/she may receive benefit checks directly from the insurance carrier for services rendered by the provider. The undersigned patient hereby agrees to immediately forward said checks to TheraPhysical, upon receipt of the same. This assignment of benefits has been explained to my full satisfaction, and I understand its nature and effect.

Patient Signature _____ **Date** _____

PROTECTED HEALTH INFORMATION

This notice describes how care information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

TheraPhysical office abides by the terms described in this policy.

TheraPhysical office discloses your protected health care information for the following reasons:

1. To share with their treating health care providers regarding your health care.
2. To submit to insurance companies or Worker`s comp claim to verify that treatment has been rendered.
3. Releasing information required by State or federal Public Health law.
4. Emergency situations
5. Abuse, neglect or domestic violence

Any other uses or disclosures will only be made with your specific written prior authorization.

You have the right to:

1. Revoke authorization, in writing at any time by specifying what you want restricted and to whom
2. Obtain an accounting of disclosures of your protected health information

Thera Physical office reserves the right to change the terms of this notice and to make new provisions for all protected health information that it maintains. Patients may also get an updated copy upon request at any time by asking the staff.

I acknowledge that I have received and reviewed this notice with full understanding. **Initial** _____

INSURANCE CHECKS SEND TO THE PATIENT

Insurance companies may send checks to the patient for service performed by TheraPhysical. If you receive any checks, do not cash or deposit them. Instead, please endorse the back of the checks and either mail or bring in to TheraPhysical.

I, _____have been informed by TheraPhysical that checks from my insurance company may be sent directly to me. I agree to endorsee these checks on the back and mail or bring in to TheraPhysical. In the event that falsely withhold such checks, I understand I am responsible for the amount due to TheraPhysical. **Initial** _____

Patient Signature _____ **Date** _____