



### ASSIGNMENT OF BENEFITS

I assign to **Holsman Physical Therapy and Rehabilitation, PC** all of my benefits and rights under any insurance contracts for payment of services rendered to me by **Holsman Physical Therapy and Rehabilitation, PC**. I authorize all information regarding my benefits under any insurance policy related to any claim to be released to **Holsman Physical Therapy and Rehabilitation, PC**; I authorize **Holsman Physical Therapy and Rehabilitation, PC** to file insurance claims on my behalf for services rendered to me. I direct that all such payments go directly to **Holsman Physical Therapy and Rehabilitation, PC**. I authorize **Holsman Physical Therapy and Rehabilitation, PC** to act in my behalf and report any suspected violations of proper claims practice to the proper regulatory authorities.

I authorize **Holsman Physical Therapy and Rehabilitation, PC** to obtain counsel and enter into legal or other action on my behalf and/or in my name, including the arbitration/dispute resolution process, to collect such sums due, should the sums not be paid within the legally prescribed timeframe. In the event that **Holsman Physical Therapy and Rehabilitation, PC** elects to bring a lawsuit or petition for arbitration/dispute resolution against the insurance carrier. I assign my rights and interest under the medical expense benefits and/or PIP section of any insurance policy under which I am entitled to proceed for benefits. This assignment shall allow an attorney of **Holsman Physical Therapy and Rehabilitation, PC** choosing to bring suit or submit to 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 **Holsman Physical Therapy and Rehabilitation, PC** to appoint an attorney of this choice to represent me directly against an insurer from which I may collect PIP benefits and to bring a claim in a forum of his choice. This appointment is intended to enable the attorney to collect the bills of **Holsman Physical Therapy and Rehabilitation, PC**.

I agree and acknowledge that I may receive checks directly from the insurance carrier for services rendered by the provider. I agree to immediately forward said checks to **Holsman Physical Therapy and Rehabilitation, PC** upon receipt.

A photocopy of this assignment shall be as valid as the original. This assignment of benefits has been explained to my full satisfaction and I understand its nature and effect.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_