

Assignment of Benefits to  
**ADVANCED PHYSICAL THERAPY CENTER**  
3367-A Hwy 16 N, Denver, NC 28037

Patient Name \_\_\_\_\_ Primary Insurance Name \_\_\_\_\_

Policy# \_\_\_\_\_ Group # \_\_\_\_\_

Social Security # \_\_\_\_\_ Patient Date of Birth \_\_\_\_\_

Insured's Name \_\_\_\_\_ Insured Date of Birth \_\_\_\_\_

Employer \_\_\_\_\_ Claim # (if applicable) \_\_\_\_\_

*Secondary Insurance Name & Policy #* \_\_\_\_\_

*Insured's Name & Date of Birth* \_\_\_\_\_

I hereby assign to Advanced Physical Therapy Center all insurance and settlement benefits due to me to the full extent of my financial obligation.

I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment of benefits.

I authorize the use of this signature on all insurance submissions.

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

I authorize Advanced Physical Therapy Center to deposit insurance checks on my behalf.

If necessary, I authorize Advanced Physical Therapy Center to initiate a complaint to the Insurance Commissioner against my insurance company.

I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that my insurance coverage is a relationship between myself and the insurance company.

I understand that my account will become delinquent 30 days after discharge. I understand that a finance charge of 18% per month will be added to the balance until full payment is completed. I will also pay any charges incurred such as collection, court, and attorney fees.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
Signature of Policyholder or Responsible Party

\_\_\_\_\_  
Witness

**We look forward to building a successful relationship with you that lasts a lifetime!**