

# Personalized Therapy, LLC

## Occupational & Physical Therapy for Children & Adults

### SPECIFIC AND IRREVOCABLE AUTHORIZATION AND ASSIGNMENT OF BENEFITS

**TO:** Personalized Therapy, LLC

I do hereby authorize you to release any information you deem appropriate concerning my health condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred at your clinic by me.

1. I authorize and assign the direct payment to you of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole or in part upon charges made for your services.
2. I fully understand that my financial obligation to the medical provider above is not contingent on any settlement, claim, judgment or verdict which may be recovered, if there is not recovery, I fully accept responsibility for the debt that I have incurred.
3. I give assignment and lien against any claims against a third party whose negligence may have caused my injury, up to the amount of the bill, for treatment.
4. In the event any insurance company obligated by contractual agreement refuses to make such payment to me or to you for the charges made for your services and refuses the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent data below) and authorize you to prosecute said action either in my name or your name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit. However, it is understood that until all reasonable efforts have been made to collect the sums due from the insurance company(s) contractually obligated, you will refrain from attempts and efforts to collect the amounts owed directly from me. I understand that whatever amounts you do not collect from insurance proceeds (whether it is all or part of what is due) I personally owe you.
5. I waive the Statue of Limitations regarding my doctor's right to recover.
6. As the owner and/or beneficiary of this policy, I further direct that reimbursement for ALL services be paid DIRECTLY to my physician, the provider of services, under the terms of my contract with this company. NO other third party, including any attorney, would receive payment of my medical bills, except the treating physician.
7. I agree never to rescind this document and that a rescission will not be honored by my attorney and/or any insurance carrier. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney will honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him.
8. I waive my confidentiality rights and agree to have my attorney and/or insurance carrier disclose settlement amounts with my provider.
9. I hereby grant to Personalized Therapy, LLC, the power to endorse my name upon any checks, drafts, or other negotiable instruments representing payment from any insurance company representing payment for treatment and health care rendered by Personalized Therapy, LLC, I agree that any insurance payment representing an amount in excess for the charges for treatment rendered will be credited to my/our account or forwarded to my/our address upon request in writing to Personalized Therapy, LLC.
10. I hereby grant Personalized Therapy to receive a letter of protection which is document that we receive from your attorney, stating that he/she will protect our interests at the time of settlement. Your attorney will need your authorization to give us this letter so he/she can pay us out of the settlement proceeds.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient/Guardian Signature

22593 THREE NOTCH ROAD • CALIFORNIA, MD • 20619  
PHONE: 301.862.2505 • FAX: 301.862.2548