Dynamic THERAPIES SM
Occupational Therapy
Physical Therapy
Speech Therapy
50 E. Foothill Blvd., Ste. 100
Arcadia, CA 91006
p. 626.445.2400
f. 626.445.2419
www.dynamic-

AUTHORIZATION & ASSIGNMENT OF BENEFITS TO MEDICAL PROVIDER

Pay Medical Provider: ***Dynamic Therapies, Inc., 50 E. Foothill Blvd., Ste. 100, Arcadia, CA 91006***

Patient's Name:_____
Insurance Company: _____
Address: _____
_____

Insured's Name: _____
Policy No./Group No.: _____
Insurance Company Telephone No.: _____

1. I authorize the RELEASE OF ANY INFORMATION concerning my health to any insurance company, attorney or adjuster as necessary to process any claims for payment to the above named medical provider's charges incurred by me. I also authorize the insurance company to furnish to the medical provider named above any information regarding my claims under the policy of Social Security Act.
2. In consideration of the above-named medical provider's rendering of treatment (without immediate compensation), I authorize and IRREVOCABLY ASSIGN MY RIGHT TO PAYMENT of the above named medical provider's bill, from the proceeds of any judgment or settlement in my case (any insurance company providing coverage to me for such expenses).
3. With reference to any contracted insurance providing coverage to me for the above medical provider's treatment I understand, authorize, and agree that no payments due to me under said contract of insurance. No payment shall be made to me any other medical expenses incurred until the above medical provider's BILL FOR MY TREATMENT IS FIRST PAID IN FULL.
4. I give assignment and lien in any claims against a third party whose negligence may have caused my injury, up to the amount of the bill for treatment.
5. In the event any insurance company, obligated by contractual agreement to make payment to me or to the physician, refuses to make such payment upon demand, I hereby IRREVOCABLY ASSIGN AND TRANSFER to the medical provider any CAUSE OF ACTION that exists in my favor against any such company, and authorize the medical provider to prosecute that action either in my name or in the name and further to compromise, settle, or otherwise resolve said claims.
6. I waive the STATUTE OF LIMITATIONS regarding my provider right to recover.
7. I permit a COPY OF THIS AUTHORIZATION to be used in place of the original.
8. I hereby appoint the above named medical provider and any of their duly authorized agents or employees to endorse any and all checks, drafts or money orders made payable to the undersigned, for medical services or the like which have been, or are to be, performed by the medical provider.
9. I give consent for Dynamic Therapies, Inc. to bill my health insurance on my behalf. I AM FULLY RESPONSIBLE FOR THE YEARLY DEDUCTIBLE AND ANY CO-PAYMENTS AND OR CO-INSURANCE PAYMENTS DUE at time of service.
10. I fully understand that I am directly, personally, and fully responsible to Dynamic Therapies, Inc. for all medical bills submitted on my behalf for services rendered.

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Insured's Signature (or Parent/Guardian's Signature)

NOTICE TO INSURANCE COMPANY OF ASSIGNMENT

You are instructed to PAY DIRECTLY TO THE above named medical provider at the office for all professional services rendered to my child by this office. This instruction to you is an assignment of my rights under the medical coverage of the insurance policy or my rights under the third party liability claim. Any sum of money paid under this assignment shall be credited to my account.

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Insured's Signature (or Parent/Guardian's Signature)