Assignment of Benefits Form

Patient:_____ **Date of Birth**:_____/_____/_____ **SS# / ID#:**:_____

Ins. Group:_____ **Employer:** _____

I hereby authorize my Insurance Company to pay by check made out and mailed to: **Westlake Physical Therapy, Inc.**

OR

If my current policy prohibits direct payment to medical provider, I hereby authorize you to make out the check to me and mail it as follows:

Patient Name:_____

C/O Westlake Physical Therapy, Inc.
110 Jensen Ct. Ste. 2-C
Thousand Oaks, CA 91360

Phone: (805)413-1070 **Fax**: (805)413-1076 // **W.L.V NPI**: 1043236078 **T.O NPI:** 1558498337

For the professional or medical expense benefits allowed by my current insurance policy as payment toward the total charges for the professional services rendered.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. **I understand that I am responsible for any balance of charges not covered by my insurance company which include the deductible & co-insurance.**

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

-I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

-I authorize Westlake Physical Therapy, Inc. to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

ATTENTION PATIENTS!!!

- ALL COPAYS & CO-INS AMOUNTS MUST BE PAID PRIOR TO SEEING THE PHYSICAL THERAPIST
- IF YOU HAVE A **HIGH DEDUCTIBLE** POLICY, **PAYMENT IS DUE AT THE TIME OF SERVICE!**
- IF YOU ARE A NEW PATIENT AND/OR IT HAS BEEN 1 YEAR OR MORE SINCE YOUR LAST VISIT, THE FOLLOWING WILL BE REQUESTED:
  - NEW INFORMATION PACKET
  - COPY OF INSURANCE CARD
  - COPY OF PHOTO IDENTIFICATION

IF THIS INFORMATION IS NOT OBTAINED WE MUST RE-SCHEDULE YOUR APPOINTMENT. **(NO EXCEPTIONS)**
IT IS YOUR RESPONSIBILITY TO NOTIFY THE RECEPTIONIST IF YOUR INSURANCE COMPANY HAS CHANGED OR CHANGES DURING THE COURSE OF YOUR TREATMENT. IF YOU FAIL TO NOTIFY US PRIOR TO YOUR OFFICE VISIT
YOU WILL BE RESPONSIBLE FOR ALL PHYSICAL THERAPY CHARGES ASSESSED.
PLEASE DIRECT ANY QUESTIONS REGARDING YOUR INSURANCE TO THE RECEPTIONIST.
THANK YOU!!!

_____ _____
Signature of patient or Legal Guardian (if under 18) Date

_____
Witness