

INSURANCE ASSIGNMENT FORM
for all insurance other than workers' compensation or no-fault

PLEASE FILL IN FORM COMPLETELY TO AVOID INSURANCE PAYMENT DELAY!

PRIMARY INSURED INFORMATION

Insurance: _____ Ins. Tel#: _____ Insured SS#: _____

Insured: _____ Relation: Self ___ Spouse ___ Parent ___ Other ___
 Last Name First Name

ID#: _____ Group # _____ D.O.B. _____ Male ___ Female ___

Employer: _____

SECONDARY INSURED INFORMATION

Insurance: _____ Ins. Tel#: _____ Insured SS#: _____

Insured: _____ Relation: Self ___ Spouse ___ Parent ___ Other ___
 Last Name First Name

ID#: _____ Group # _____ D.O.B. _____ Male ___ Female ___

Employer: _____

Name of Patient (Print): _____

In consideration of services rendered or to be rendered, I hereby assign to the provider, **Life Physical Therapy & Wellness, P.C.**, and/or its assignees so much of my first party insurance benefits and rights as shall equal the full amount of the bill for such services and the provider or its assignees may secure in my name. If the above provider is an in-network provider of my primary insurance, then my financial liability is limited to that which these insurance companies require me to pay (e.g.: insurance co-payment, co-insurance, deductible, etc.)

GUARDIAN/PATIENT SIGNATURE

DATE