ASSIGNMENT OF INSURANCE BENEFITS

Patients with Medicare Coverage:

I request that payment of authorized **Medicare Benefits** be made on my behalf to **Brande Moffatt, MPT, Women's Health Physical Therapy** for any services furnished me by the supplier. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents for any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other insurance is indicated in item 9 of HCFA 1500 form or elsewhere on other approved claim forms, or electronically submitted claims, my signature authorizes releasing the information to the insurer of the agency shown.

In Medicare assigned cases the physician or supplier agrees to accept the charge of determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible determination of the Medicare carrier. I understand that I will be responsible for any late cancellation (< 48 hours notice), no show fees, or equipment fees, as these are not billable to Medicare. I understand that it is important that I show up on-time for the appointment time that has been scheduled for me. If I do not, I understand that I may be responsible for the portion of my visit that will not be billable to Medicare.

______________________________ ____________________

Signature Date

Patients with Private Insurance Coverage/Secondary Insurance:

I hereby authorize payment of medical benefits to **Brande Moffatt, MPT, Women's Health Physical Therapy** for all insurance benefits otherwise payable to me. I understand that I am financially responsible for all charges NOT covered by this assignment.

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Name of Insured Date of Birth Today's Date