Assignment of Benefits to Optimize Therapy and Fitness

Patient Name:_____

Insurance Policy #:_____

Insured Name:_____Insured Date of Birth_____

Your relationship to the Insured: ❑ Parent ❑ Spouse ❑ Other:_____

Claim #_____

I hereby instruct and direct _____ insurance company to pay by check made out and mailed to:

Optimize Therapy and Fitness
P.O. Box 156
Fulton, MD 20759

If my/this current policy prohibits direct payment to doctor, I hereby also instruct and direct you to make out the check to me and **mail it to the above address** for the professional or medical expense benefits allowable, and otherwise payable to me under 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.

This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

(Check each box and sign at the bottom)

- ❑ A photocopy of this Assignment shall be considered as effective and valid as the original.
- ❑ I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment of benefits.
- ❑ I authorize the use of this signature on all insurance submissions.
- ❑ I authorize Optimize Therapy and Fitness to deposit checks made in my name.
- ❑ I authorize Optimize Therapy and Fitness to initiate a complaint to the Insurance Commissioner for any reason on my behalf.
- ❑ I understand that I am financially responsible for all charges whether or not paid by insurance.

Dated this _____ day of _____, 20_____.

_____ _____

Signature of Policyholder Witness

_____

Signature of Claimant, if other than Policyholder