PT Unlimited, Inc
4146 Library Rd
Suite 1A
Pgh, PA 15234

AUTHORIZATION TO RELEASE INFORMATION/ASSIGN BENEFITS

Patient Name: ______________________________ Date of Birth: ____________
Start of care date: __________________

I consent to the release, from the medical record, of any information that may be required by third party payors when such information is necessary to reimburse healthcare providers or is necessary to make payment pursuant to a policy of insurance.

___CERTIFICATION-AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary or carriers any information needed for this or a related Medicare claim. I request that the payment or authorized benefits be made on my behalf. I assign the benefits payable for this service to the organization furnishing the services or authorize such organization to submit a claim to Medicare for payment for me.

___ ASSIGNMENT OF BENEFITS

I hereby authorize payment directly to PT Unlimited, Inc. for any applicable third-party payment for therapy services, not to exceed the provider's regular charges for this period of service. I understand that I am financially responsible for charges not covered by this assignment. I agree that any payment made by any third-party payor shall not prevent it from taking action in connection with the validity of my policy nor shall such payment in any event waive any of the terms, conditions or limitations thereof. If assignment of the third-party payor benefits is not acceptable, please make a check payable to the provider and forward to PT Unlimited, Inc., 1638 Tiffany Ridge Drive, Pittsburgh, PA 15241.

_ACKNOWLEDGE OF RECEIPT

My signature acknowledges my receipt of this Medicare message from PT Unlimited, Inc. on _______________ and does not waive any of my rights to request a review or make me liable for any payment, except as provided by law.

______________________________________ ____________________
Signature of patient/guarantor Date

______________________________________ ____________________
Signature of responsible party Date