

# HEALTH-PRO PHYSICAL THERAPY, INC.

110 La Casa Via, Suite 100, Walnut Creek, CA 94598  
Phone: 925-935-4866 Fax: 925-935-8873

Date: \_\_\_\_\_

Patient: \_\_\_\_\_

Employer: \_\_\_\_\_

Claim#/Group # \_\_\_\_\_

SS#/ID#: \_\_\_\_\_

I hereby instruct and direct \_\_\_\_\_ Insurance Company to pay by check made out and mailed to:

Health-Pro Physical Therapy, Inc.  
110 La Casa Via, Suite 100  
Walnut Creek, CA 94598

Or if my current policy prohibits direct payment to the physical therapist, I hereby also instruct and direct you to make out the check to me and mail it as follows:

Health-Pro Physical Therapy, Inc.  
110 La Casa Via, Suite 100  
Walnut Creek, CA 94598

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 within the allowance of my patient responsibility according to my physical therapy benefits per my insurance plan.

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 Health-Pro Physical Therapy to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

I authorize Health-Pro Physical Therapy, Inc. to deposit checks received on my account when made out to the Patient.

Dated at Health-Pro Physical Therapy, this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_

\_\_\_\_\_  
Signature of Policyholder (Private insurance)

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Signature of Claimant, if other than Policyholder (Worker's Compensation, MVA, etc)