

**ASSIGNMENT OF BENEFITS, PAYMENT RESPONSIBILITY AND
AUTHORIZATION FOR TREATMENT/RELEASE OF INFORMATION**

PATIENT: _____
PROVIDER: Monmouth Rehab Professionals

1. In consideration of services rendered to the above named patient, I hereby authorize payment and assign all of my rights and benefits under contracts for payment, to the above named provider of health services of any and all insurance benefits to which I may otherwise be entitled for services rendered by the provider but not to exceed the provider's regular charges for such services.
2. Provider will no condition my treatment, payment, or eligibility for benefits on whether I provide authorization for the requested use or disclosure of information pertaining to my treatment or condition. Further, I understand (i) that I have the right to inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights) and (ii) that I have the right to refuse to sign this authorization.
3. I certify that the information given by me in applying for payment under my insurance contract is correct. I authorize any holder of medical or other information about myself, to release to Provider any information needed for this or a related claim. I request that payment of authorized benefits be made on my behalf for services rendered by Provider. I understand that this request is effective until revoked, and I agree to pay any co-payment or deductible that is my responsibility under my insurance entity. I permit a copy of this signature to be used in place of the original.
4. In the event that I receive payment from my insurance company for services rendered by Monmouth Rehab Professionals, I agree to endorse that check to Monmouth Rehab Professionals and deliver same to them. I understand that I should not keep that money.
5. In the event that the provider's charges are outstanding, I hereby authorize the provider to file such claim in my behalf so that the provider may realize payment of its charge. I understand that if the provider does not receive payment from this insurer, I am personally responsible for the provider's charges.
6. I hereby authorize Provider to furnish any and all information with respect to any illness or injury, medical history, consultation, prescriptions, or treatments, and copies of all medical records upon written request to the insurance contractor. A Photostat copy of this authorization shall be considered as effective and valid as the original. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the Provider and may no longer be protected by federal or state law.
7. THE UNDERSIGNED, agree that the provisions hereof shall continue in full force and effect until Provider has received written notice of termination signed by the undersigned; provided, however, that the provisions of paragraphs 2 and 3 shall survive any such termination.
8. THE UNDERSIGNED, acknowledge that the Provider has disclosed to the undersigned that no physician owns any interest in Provider.
9. THE UNDERSIGNED, understands that they have a choice of rehabilitation service providers.

Patient's signature/Legal Rep. Date

Witness

Date

Financially responsible party (if under age of 18)

Date