Jones & Cowen Physical Therapy
283 E. Railroad Ave. / P. O. Box 1615
Giddings, Texas 78942

Patient's Name: _____

ASSIGNMENT OF INSURANCE BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize the _____Insurance Company to pay directly to Jones & Cowen Physical Therapy benefits due me, if any, by reason of services described in the statement rendered and are provided for in the above policy contract with aforementioned Insurance Company. I will be responsible for all such charges incurred or for all charges in excess of whatever sum may be paid by the Insurance Company above mentioned. I authorize the release of any medical information necessary to process this claim.

MEDICARE PATIENTS CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION, PAYMENT REQUEST:

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Jones & Cowen Physical Therapy for any services furnished me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Date: _____ Signature: _____