



**CALDWELL THERAPY CENTER, P.A. (CTC)
CALDWELL COMMUNITY PHYSICAL THERAPY, P.A. (CCPT)
700 Passaic Avenue
West Caldwell, NJ 07006**

PATIENT AGREEMENT AND ASSIGNMENT OF BENEFITS FORM

PATIENT NAME: _____

I irrevocably assign to CTC/CCPT all my rights and benefits under any insurance contracts for payment for services rendered to me by CTC/CCPT. I irrevocably authorize all information regarding my benefits under any insurance policy relating to any claims by CTC/CCPT, to be released to CTC/CCPT. I irrevocably authorize CTC/CCPT to file medical insurance claims on my behalf for their services rendered to me. I irrevocably direct that all such payments for such services go directly to CTC/CCPT. I irrevocably authorize CTC/CCPT to act in my behalf and report any suspected violations of proper claims practices to the governing regulatory authorities.

I understand and agree that I am responsible for all services rendered to me by CTC/CCPT and that although I have authorized CTC/CCPT to bill my insurance company on my behalf; I clearly understand that I am fully responsible for the timely payment of the bill. If for any reason the insurance company does not pay any portion of the bill, I further agree to make arrangements for prompt payment of any balances due for the services rendered to me by CTC/CCPT. I waive any statute of limitations regarding CTC/CCPT's right to recover any monies owed them by me. I hereby give assignment and lien against any claims against a third party whose negligence may have caused the patient injury, up to the amount for the bills for treatment. This assignment and lien is to be extended to any monies paid to myself, the insured, and or an attorney. A copy of this can be considered an original for insurance payment. I authorize the release of any medical information necessary to process the claims made on my behalf.

I hereby consent to a physical therapy or occupational therapy evaluation and treatment as recommended by my referring physician and my therapist.

This agreement and assignment of benefits has been fully explained to my full satisfaction, and I understand its nature and effect.

PATIENT SIGNATURE: _____

DATED: _____