

Assignment of Benefits to Innovative Spine Rehab/WLRPT, Inc.

Patient Name: _____

Insured Name (if different than patients name): _____ Insured Date of Birth: _____

Your relationship to the Insured: Self Spouse Parent Other: _____

I, the undersigned, acknowledge that I have been provided the Notice of Privacy Practices by Innovative Spine Rehab/WLRPT, and I have requested a copy if so desired.
_____ (Initial here)

I hereby instruct and direct _____ insurance company to pay by check made out and mailed to:

Innovative Spine Rehab/WLRPT, Inc.
11900 Kanis Road Ste D4
Little Rock, AR 72211
501-221-6009

If my/this current policy prohibits direct payment to doctor, I hereby also instruct and direct you to make out the check to me and **mail it to the above address** 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.

- A photocopy of this Assignment shall be considered as effective and valid as the original.
- I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment of benefits.
- I authorize the use of this signature on all insurance submissions.
- I authorize ISR/WLRPT, Inc. to deposit checks made in my name.
- I authorize ISR/WLRPT, Inc. to initiate a complaint to the Insurance Commissioner for any reason on my behalf.
- I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature of Policyholder

Witness

Signature of Claimant, if other than Policyholder

Date