



5317 Limestone Road • Wilmington, DE 19808 • 302-239-1613

**ASSIGNMENT OF BENEFITS / RELEASE OF RECORDS / PAYMENT AGREEMENT**

ASSIGNMENT OF BENEFITS: PATIENT INITIAL HERE:

To Insurance Company: I hereby direct and instruct you to make payment directly to the undersigned provider(s) for medical claims submitted by them on my behalf for medically necessary treatment.

Your denial or delay to do so in a timely manner will be considered just cause for provider or myself to file a complaint with the Insurance Commissioner. I hereby give my permission to the undersigned provider to file this complaint on my behalf if deemed necessary.

RELEASE OF RECORDS: PATIENT INTIAL HERE:

To Provider of Services: I herby authorize you to release to any attorney, physician, or insurance company (involved in my case) any medical or their records or information necessary to process my claim. These records are to be utilized for the ultimate recovery of benefits in my case of injury/illness sustained on (date):

PAYMENT AGREEMENT: PATIENT INITIAL HERE:

I understand that my insurance contract is an agreement between the insurance company and myself. I acknowledge that your office is willing to prepare the necessary reports and assist me in collecting from the insurance company that which is due to you for my medically necessary care and treatment.

I agree and acknowledge that I am ultimately responsible to you for payment of any balance due, including unpaid deductibles and/or unpaid percentage amounts due to you according to my policy coverage, in the event you are unable to collect from my insurance carrier or attorney in the case where you are holding an attorney lien on my behalf.

I understand that I may elect to be billed monthly or at the time of each visit for the balance due to you from each visit.

**Select One Option and Initial**

I elect to pay the unpaid balance at the time of each visit. (initial here)

I elect to be billed for the balance at the end of each month. (initial here)

I elect to have outstanding bills sent to my attorney to be paid at the time of settlement. If there is not a settlement, I understand and agree that I will still be responsible for payment to you for services provided by Deep Muscle Therapy Center. (initial here)

PATIENT'S NAME:

ADDRESS:

PATIENT'S SIGNATURE: DATE: