Insurance Benefit Form

I _____ authorize FYZICAL Therapy & Balance Centers to render treatment, furnish information and medical records to my physician, insurance carriers, appeal claims denied by my insurance company on my behalf, attorney or employer concerning myself or my dependent's illness and treatment. I hereby assign to the provider all payment for medical services rendered to myself or my dependents. I understand I am responsible for any amount not covered by insurance.

I acknowledge that FYZICAL Therapy & Balance Centers has contacted my insurance company on my behalf and made an earnest effort to accurately obtain my insurance benefits. I further understand that this information has been provided directly by a representative of my insurance company and that FYZICAL Therapy & Balance Centers cannot be held responsible for misinformation given to them by my insurance company.

I understand that in the event that the above benefits are inaccurate that THE ACTUAL AND TRUE BENEFITS OF MY POLICY WILL BE INDICATED ON MY EXPLANATION OF BENEFITS. I will be responsible for the amount my insurance company states are my responsibility on the explanation of benefits.

Amounts due are estimates based upon an average fee schedule and the information provided by your insurance company.

By typing my name below, I acknowledge receiving the INFORMATION ABOVE

_____	_____	_____	_____
Client Name (Signature)	**Time**	**Date**	**Last 4 SSN**

FYZICAL _____

Phone: 561-432-0111 Fax: 561-432-1075