ADLER THERAPY GROUP

ASSIGNMENT OF BENEFITS

I hereby do authorize and direct my insurance company to make payment to Adler Therapy Group, benefits allowable and otherwise payable to me and/or my dependents. I understand that I am responsible for charges not paid under this assignment. I hereby authorize the therapist to release all information necessary to secure payment of benefits. I authorize the use of this signature in all my insurance submissions.

Patient's Signature _____ Date _____

MEDICARE AUTHORIZATION (ONLY)

I request that payment of authorized Medicare benefits be made either to me or on my behalf to JP THERAPY, LLC DBA ADLER THERAPY GROUP for any services furnished to me. 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. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the therapist or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Patient's Signature _____ Date _____

INSURANCE FILING AUTHORIZATION FORM

I understand that your signature on this form gives the authorization to release any medical or other information necessary to process my health insurance claims for the treatment I receive at their facility. I also authorize direct payment of medical benefits to Adler Therapy Group for services rendered.

Patient Name: _____

Patient or Authorized Persons Signature: _____

Authorized Persons relationship to Patient: _____

Date: _____ *This authorization is good for One (1) year from date of service*

Office Staff Signature: _____