ASSIGNMENT OF INSURANCE BENEFITS AND PATIENT RESPONSIBILITY

I hereby authorize my insurance company and/or my attorney to pay Lee Miller Rehabilitation and Associates, LLC. directly, such sums as may be due for professional services rendered. The benefits referred to herein would be payable to me if I did not make this assignment. I understand that I am personally responsible for charges not covered by this assignment, at the time of treatment (such as co-payments and deductible charges). In the event demand for payment is made and not received within 30 days from the date of last treatment, interest of one and one half percent per month will accrue and if legal proceedings are instituted and result in a monetary judgment in favor of the practice, attorney's fees of one third of the indebtedness will be assessed as well as all court costs expended. I hereby agree to waive the defense of the statute of limitations as it pertains to any claim filed against me beyond three years (or other statutory period) after services were rendered. This assignment shall be in effect for this date and all subsequent dates while under the care of Lee Miller Rehabilitation Associates, LLC.

ASSIGNMENT OF BLUE CROSS/BLUE SHIELD AND/OR MEDICARE BENEFITS

I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physical therapy services to Lee Miller Rehabilitation and Associates, LLC. and authorize same to submit a claim to Blue Cross/Blue Shield and/or Medicare for payment. I understand the charges may exceed payment, and if greater, I will be responsible for that amount and any deductible owed. This assignment is for this date and all subsequent dates while under the care of Lee Miller Rehabilitation Associates, LLC.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize Lee Miller Rehabilitation Associates, LLC. to furnish to my attorney, doctor, or insurance company responsible for coverage of services rendered, or their representatives; all information relative to any medical conditions from disease and/or injury and treatment past and present. It is hereby agreed that Lee Miller Rehabilitation Associates, LLC. is relieved of any liability whatsoever, from the furnishing of such information.

AUTHORIZATION FOR TREATMENT

I hereby authorize, Lee Miller Rehabilitation Associates, LLC. to administer physical therapy services as deemed necessary.

I do____/do not____ require a social work consultation at this time.

DATE PATIENT, PARENT OR GUARDIAN'S SIGNATURE

DATE SIGNATURE OF WITNESS