



NAT'L MEDICAL REHABILITATION

9400 LIVINGSTON ROAD, SUITE 450 FORT WASHINGTON, MD 20744
(301) 248-8900 Fax (301) 248-8915 • rehabmedonline.com

Physical Medicine & Rehabilitation • Physical Therapy

ASSIGNMENT AND AUTHORIZATION

PATIENT NAME: _____

DATE OF INJURY: _____ PATIENT DATE OF BIRTH: _____

Nat'l Medical Rehabilitation, located at 9400 Livingston Road Suite 450, Fort Washington, Maryland 20744, is hereby authorized to disclose and/or furnish my attorney(s) with any and all medical information, bills, and/or records in their possession related to my injury noted above, which may be requested in reference to any illnesses and injuries which I have suffered.

Furthermore, I irrevocably assign to *Nat'l Medical Rehabilitation* and authorize and direct my attorney(s) to pay from the proceeds of my recovery in my case all reasonable fees for services provided by *Nat'l Medical Rehabilitation*, including fees for preparation and testimony, as a result of the injury of condition heretofore mentioned. I understand that this in no way relieves me of my personal primary obligation to pay for such services and that the signing of this form does not prohibit customary billing by *Nat'l Medical Rehabilitation*. All bills shall be paid promptly in the usual manner.

It is further understood that the statute of limitations in this state is three (3) years from the time the said services were last performed and I understand that due to long delays in trial dockets, many cases are not tried or settled until a date which is beyond the three (3) year period of time following the last date of service performed. In view of this, I hereby agree that the statute of limitations with respect to any claim for services mentioned above will not begin to run until there is a denial in writing by me of any balance claimed to be due and owing to *Nat'l Medical Rehabilitation*.

Signature: _____ Date: _____

Address: _____

PERSONAL REPRESENTATIVE (print name & relationship, affix signature)

TODAY'S DATE

THE UNDERSIGNED ATTORNEY FOR THE PATIENT REFERRED TO ABOVE HEREBY AGREES TO COMPLY FULLY WITH THE FOREGOING "AUTHORIZATION AND ASSIGNMENT" AND AGREES TO ADVISE THE NAMED ASSIGNEE IN WRITING THE STATUS OF THE CLAIM OF THE PATIENT WITHIN TEN (10) DAYS OF THE REQUEST, AND AGREES TO NOTIFY THE ASSIGNEE IF THE ATTORNEY CEASES TO REPRESENT THIS PATIENT AND/OR IF THE CLAIM IS DROPPED OR DENIED.

Attorney's Signature & Date: _____