



KAH Premium Physical Therapy

97H Main St.
Stony Brook, NY 11790
P (631) 751-6680
F (631) 675-6264

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____
(Insurance Co.) and assign directly to KAH Premium Physical Therapy all medical benefits, if any otherwise payable to me for service rendered. I understand that I am fully responsible for all changes whether or not paid by my insurance company. I hereby authorize KAH Premium Physical Therapy to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature of Insured/Guardian

Date

MEDICAL AUTHORIZATIONS

I request that payment of authorized Medicare benefits be made either to me or on my behalf to KAH Premium Physical Therapy for any services furnished me by that office. I authorize any hold of 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 that 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 any electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for deductible, Co insurance, and non-covered services. Co insurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature

Date