ALLEN LETGOLTS | Doctor of Physical Therapy

ASSIGNMENT OF BENEFITS

Patients Name: _____

Patients Identification Number: _____

Primary Insurance Company: _____

Secondary Insurance Company: _____

I hereby authorize, Allen Letgolts, D.P.T and/or Letgolts Method Physical Therapy P.C., to furnish to my insurance carrier(s) any and all requested information concerning my health care.

I also authorize my insurance carrier(s) to pay Allen Letgolts, D.P.T. and/or Letgolts Method Physical Therapy P.C., directly for services rendered.

ANY PAYMENT DENIED BY MY INSURANCE CARRIER WILL BECOME MY RESPONSIBILITY.

I have seen a physical therapist/chiropractor or had home health care _____ times this calendar year.

I have not seen a physical therapist/chiropractor or had any home health care this year _____.

ALL PATIENTS:
I understand that a current prescription/referral may be required for your insurance carrier to cover my appointments. I understand that a new prescription/referral may be required during my treatment period and it is my responsibility to contact my referring doctor for a new prescription/referral.

Signed: _____ Date: _____
(Patient or Legal Guardian)

Letgolts Method
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