Boca Medical Therapy
(954) 363-7494
Fax (954) 363-7497

Patient: _____ DOB _____

Policy:/Claim#: _____

Other: _____

I hereby instruct and direct _____ Insurance Company to pay by check made out and mailed to: **Boca Medical Therapy, 1000 East Hillsboro Blvd, #104, Deerfield Beach, Fl 33441**

or

If my current policy prohibits direct payment to provider, I hereby also instruct and direct you to make out the check to me and mail it to me in care of:

Boca Medical Therapy, 1000 East Hillsboro Blvd, #104, Deerfield Beach, Fl 33441

For the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above named assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information/medical records pertinent to my care/case to any physician, hospital, insurance company, adjuster or attorney involved in my care/case. _____ **(Patient Initial)**

I authorize the provider, (facility) to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Dated this _____day of _____20_____

_____ _____

Signature of Policyholder (Patient) Witness

_____

Signature of Claimant, if other than Policyholder