Assignment Of My Benefits

For Commercial Insurance, POS, Medicare, Medicaid, Med-Pay, PIP, Lien, Workers Compensation, Other Liability and Private Third Party Payers

1. Benefits Info

Please provide **all** insurance cards and information, as well as your driver's license or photo ID card. Benefits will be verified between our office and your insurance however, as stated by most insurance policies, *"a verification of benefits is not a guarantee of payment"*. **You are responsible for any co-insurance, co-payment, or *unmet* deductible amount at time of service/each visit.**

2. Policy Info

I hereby instruct and direct my insurance company, attorney, and/or person(s) responsible for settlement/payment services related to my claim/case to timely discuss and provide necessary information as well as to pay via check made payable and mailed to:

Kids In Stride 2810 W. US Hwy 64 Murphy, N.C. 28906
Office: 828-516-1700 Fax: 828-516-1701

If my/this current policy prohibits direct payment to above company, I hereby also instruct and direct you to **make the check jointly payable to myself AND Kids In Stride and mail it to the above address for the allowable professional or medical expense benefits,** 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-mentioned assignee. I agree to pay, in a prompt manner, any balance of said professional service charges not paid by my insurance or designated responsible party. (co-pays, deductible, or denial). (Sign and date this document at the bottom)

- A photocopy or fax copy of this Assignment shall be considered as effective and valid as the original.
- I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster, or attorney directly involved in this case for the purpose of processing claims and securing payment of benefits.
- I authorize the use of this signature on all insurance submissions.
- I authorize Kids In Stride, Inc. to deposit insurance checks made in my name for their services.
- I authorize Kids In Stride, Inc. to initiate a complaint to the Insurance Commissioner for any reason on my behalf.
- **I understand that I am ultimately financially responsible for the services I receive whether or not paid by my insurance, settlement, or any other entity that I initially provided for said payment to Kids In Stride.**
- **I authorize the release of any information regarding my clase/claim to/from ProMotion Rehab from/to any insurance provider, attorney, adjuster or any other related party.**

***Note: Providers may not bill any patient more than has been allowed by the insurance company with which they contract.**

NOTE: We accept cases of personal injury where fault is or is NOT determined. We reserve the right to **request payment be made at the time of service** even in cases where an attorney is involved. In certain cases we may defer payment until the cases settles, however, a **lien agreement** will be required to secure payment. We **do not charge any fees** for this service even though we may not receive payment for services provided for 12-24 months. Please be informed that **we do not accept "discounted settlements". We will not change the payor to your private insurance after you have been discharged unless your case has settled and no money had been awarded.** Please understand **all** amounts are due and payable by patient or their guardian/parent (for minor patients). **The patient or guardian/parent is responsible for all charges** regardless of the outcome of the case.

If it becomes necessary for Kids In Stride to retain a collection agency or legal counsel to assist with collection of any unpaid patient responsible balance, by your signature below you agree to assume responsibility for all related fees.

Please note that any documentation requests and/or deposition appearance requests by an attorney other than your own or yourself may incur additional fees. We do not accept all cases and reserve the right to refuse service to anyone.

Dated this _____ day of _____ 20____.

Signature of Policyholder	Witness	Signature of Claimant, if other than Policyholder

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