Diane Shiao MSPT, DPT
1941 Oak Tree Rd.
Ste #302
Edison, NJ 08820
P (732) 662-7927
F (732) 662-7928
info@revivephysicaltherapy.com

Consent for Care and Treatment

I, the undersigned, do hereby agree and give my consent for Revive Physical Therapy and Wellness Center, LLC to furnish medical care and treatment to ____,
(Print your name)
which is considered necessary and proper in diagnosing and treating his/her physical and mental condition.

Patient/ Guardian/Responsible party: __________________________________ Date: __________

STOP. Make sure you sign above.

Benefit Assignment/Release of Information

I hereby instruct and direct ____
(Primary / Secondary / Tertiary healthcare insurance)
insurance company to pay by check made out to " Healthcare Provider" named to the right and mailed to the address on the right (not mine). If my/this current policy prohibits direct payment to doctor/therapist, I hereby also instruct and direct you to make out the check to me and mail it to the my address 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.

Healthcare Provider Info:
Revive Physical Therapy
and
Wellness Center, LLC
1941 Oak Tree Rd #302
Edison, NJ 08820

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, and I have agreed to pay, in current manner any balance of said professional service charges over and above this insurance payment.

(Check box and sign at the bottom)

- ☐ A photocopy of the 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, billing service, adjuster, or attorney 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 the "Healthcare Provider" named above to deposit checks made in my name.
- ☐ I authorize the "Healthcare Provider" named above to initiate a complaint to the Insurance Commissioner for any reason on my behalf.
- ☐ I understand that I am financially responsible for all charges whether or not paid by insurance.

Dated this ___ day of ___________, 20____.

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