

# *Merritt Physical Therapy & Rehabilitation*

PO Box 1078 Grundy, VA 24614  
(276) 935-6496

## **ASSIGNMENT OF BENEFITS & RELEASE OF INFORMATION**

This is to authorize Merritt Physical Therapy & Rehabilitation to make available to my insurance company and/or my attorney(s) any **medical records** or information that may aid in processing properly my claim and representing me in a claim for injuries sustained as the result of an accident or illness. I further request that copies of my bills be sent to my attorney(s) and hereby **authorize** my attorney(s) or insurance company to **pay directly to Merritt Physical Therapy & Rehabilitation all bills in full** from any funds received or held by them on my behalf regardless of the source. I also understand fully that if bills are not paid at all or paid only in part by the insurance company and/or attorney(s), that I am fully and personally responsible for all my medical expenses as presented by Merritt Physical Therapy & Rehabilitation. It was carefully explained to me and I fully understand that Merritt Physical Therapy & Rehabilitation's charges for examination, treatment, etc. are to be paid fully by me regardless of the outcome of my suit or negotiations. I further promise to pay the full amount of the bill submitted by Merritt Physical Therapy & Rehabilitation should the insurance company refuse to pay my claim or pay the bill directly to me.

## **CONSENT TO RELEASE MEDICAL INFORMATION**

This authorization or any photocopy thereof, authorizes Merritt Physical Therapy & Rehabilitation, to furnish any medical reports or findings for inspection and copying and upon request to discuss freely and render written opinions concerning diagnosis, treatment, and prognosis of my performance and physical condition. I hereby release Merritt Physical Therapy & Rehabilitation from all legal responsibility or liability that may arise from the release of the foregoing information. I have carefully read and understand the above statements and confirm this with my signature.

## **WRITTEN KNOWLEDGE OF RECEIPT**

This verifies that I received or was offered a copy of Merritt Physical Therapy & Rehabilitation's private policies (HIPAA).

## **ATTENDANCE POLICY**

We at Merritt Physical Therapy strive to provide the best possible care for our patients. This includes our commitment to a schedule that allows adequate time for each patient during your care. There will be a time slot on the schedule reserved specifically for you. To provide appropriate time for the evaluation, treatment and to obtain the best possible outcome, we expect you to be on time for your appointment. **PLEASE NOTIFY US AS SOON AS POSSIBLE WITH ALL CANCELLATIONS.** This allows for the highest level of care to be delivered in an organized and customer-focused manner, so others have an opportunity to be scheduled or rescheduled. **Thank you for your cooperation!**

\_\_\_\_\_  
**DATE**

\_\_\_\_\_  
**PATIENT OR GUARDIAN**

\_\_\_\_\_  
**WITNESS**