MIDWEST PHYSICAL THERAPY SERVICES
13911 GOLD CIRCLE #110
OMAHA, NE 68144
402-933-8383

This form instructs your Insurance Company to send payment for your treatment directly to Midwest Physical Therapy Services. We will send this form to your Insurance Company to do the following listed in the box below. If your Insurance Company does not follow what is in your contract as well as ours, we will send a complaint to the Nebraska Insurance Commissioner.

Patient Name:____
I hereby instruct and direct my Insurance Company to pay by check made out and mailed to:

MIDWEST PHYSICAL THERAPY SERVICES
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Omaha, NE 68144

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-mentioned 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.

Patient authorizes the Physical Therapist and/or Midwest Physical Therapy Services to deposit checks received on Patient's account for treatment when made out to the Patient from the insurance company.

I authorize the Physical Therapist and/or Midwest Physical Therapy Services to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

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Signature Date

Acknowledgement of receipt of Notice of Privacy Practices

I,______________________________ (patient's name) acknowledge that I have reviewed, understand, and agree to the Notice of Privacy Practices of Midwest Physical Therapy, which describes the Practice's policies and procedures regarding the use and disclosure of any of my protected health information created, received, or maintained by Midwest Physical Therapy Services.

Disclosure to Family and personal Representative Right:

I give permission to discuss my medical condition with another person.
Please list authorized individual(s) or organization(s) information can be disclosed to
Name ___________________________
Name ___________________________
Name ___________________________
Authorization Expiration Date______________ (if no date is entered, authorization will expire 1 year from current date)
****You may request a copy of our Notice at any time.**

___________________________________ _________________

Signature **Date**