ATHLETICARE
Physical Therapy & Sports Performance

Insurance Information and Assignment of Benefits

Primary Insurance:_____Policy #:_____
Claims Address:_____ Phone #:_____
Insured Name (if other than patient):_____ Insured DOB:_____
Your Relationship to the Insured: □ Self □ Parent □ Spouse □ Other:_____

Secondary Insurance:_____Policy #:_____
Claims Address:_____ Phone #:_____
Insured Name (if other than patient):_____ Insured DOB:_____
Your Relationship to the Insured: □ Self □ Parent □ Spouse □ Other:_____

Claim #:_____ Date of Injury: _____ □ Work □ Auto □ Other

I hereby instruct and direct_____ insurance company(s) to pay by check made out and mailed to:

AthletiCare ▪ 8333 S. Eastern Avenue ▪ Las Vegas, NV 89123

If my/this current policy prohibits direct payment to AthletiCare, I hereby also instruct and direct you to make out the check to me and mail it to the above 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. **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.
- I authorize the release of any medical or other information pertinent to my case to any insurance company, 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 AthletiCare to deposit insurance checks made in my name.
- I authorize AthletiCare to initiate a complaint to the appropriate state or federal agencies for any reason on my behalf.
- I understand that I am financially responsible to pay AthletiCare for all charges, whether or not paid by insurance, after 30 days from the date of service.

Patient Name:_____ Date:_____/_____/_____

Signature of Patient or Responsible Party_____