

12<sup>th</sup> Avenue Massage Therapy Group

2100 N. 12<sup>th</sup> Avenue \* Pensacola, FL 32503

ASSIGNMENT OF BENEFITS

Patient Name \_\_\_\_\_

Policy number \_\_\_\_\_

I hereby instruct and direct \_\_\_\_\_ (my insurance company) to pay by check made out and mailed directly to (write therapist name and address below):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The payment is for professional or medical expense benefits allowed, and otherwise payable to me under my current insurance policy.

**A photocopy of this Assignment shall be considered as effective and valid as the original.**

\_\_\_\_\_  
Signature of Policyholder

\_\_\_\_\_  
Signature of Claimant, if other than Policyholder

\*\*\*\*\*

AUTHORIZATION FOR RELEASE OF RECORDS

I authorize \_\_\_\_\_ (therapist) to release any medical records or other information from my files to attorneys, doctors, or insurance companies that are involved with this case. These records would be used to aid in the recovery of benefits in my case.

**A photocopy of this Assignment shall be considered as effective and valid as the original.**

\_\_\_\_\_  
Signature of Policyholder

\_\_\_\_\_  
Signature of Claimant, if other than Policyholder