ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

This is to authorize Ellis Physical Therapy Associates, Inc. (EPTA) to make any and all medical records or information that may aid in properly processing my claim and in representing me in a claim for injuries sustained as a result of an accident or illness available to my insurance company and/or attorney. I request that copies of my bills be sent to my insurance company and/or attorney and hereby authorize said parties to pay all bills in full directly to EPTA.

I understand that my insurance benefits are processed according to my individual policy benefits, exclusions, and/or limitations and that I am responsible for knowing my specific policy information. EPTA will provide a general breakdown of this information as a courtesy and is *NOT* responsible for *ANY* discrepancy in general benefit information provided versus my actual contract with my insurance company. I understand that my insurance company's claims department determines the amount owed for services provided by EPTA. I further understand that my insurance company should send me an Explanation Of Benefits *AFTER* claims are processed which shows my costs for services. EPTA only provides an *ESTIMATE* of my portion, which is payable at time of service. Actual amount due for services provided is not known until my insurance company processes *ALL* claims. I understand that the amount estimated versus the actual cost of services may be different and if different, a statement for the remaining balance due to EPTA, will be mailed to me.

I understand that if bills are not paid or paid only partially by the insurance company and/or attorney, I am personally responsible for *ALL* of my medical expenses presented by EPTA. It was carefully explained to me and I fully comprehend that EPTA's charges are to be paid *IN FULL* by me regardless of the outcome of my suit or negotiations. In the event that I am in breach of my contract to pay EPTA for my medical bills, I will be responsible for any court costs and attorney fees that result in collecting payment. EPTA, as allowed by South Carolina State Law, will utilize and report unpaid balances to a collection agency.

I further grant a lien, and this document constitutes a lien, on any funds paid/acquired through settlement, litigation, or insurance claim as a result of said illness/accident and direct insurance company/attorney to pay EPTA directly (rather than me as the patient) for services rendered on my behalf. This lien includes any and all amounts paid for Med-pay or PIP benefits.

I understand that this document will be forwarded to my attorney and that my attorney will withhold any funds necessary out of the settlement to pay this bill.

I have carefully read and understand the above statements and confirm this with my signature below.

_____	_____	_____
(Date)	(Patient or Guardian Signature)	(Witness Signature)