PARK AVENUE
Physical Therapy & Wellness

## ASSIGNMENT OF BENEFITS & PATIENT RESPONSIBILITY for NO-FAULT

***William Joseph VanVynck Physical Therapy, PC (WJVPTPC)***

First Name: _____ Last Name: _____ MI:____

Date of Accident: _____ Social Security #: _____

Insurance Carrier for Claim: _____ Telephone: _____

Claim #: _____ Adjuster's Name: _____

Adjuster's Direct Phone: _____ Fax Number: _____

**Patient Responsibility:**

- I hereby authorize WJVPTPC to release all information necessary regarding services rendered to the insurance carrier and referring physician. I agree to cooperate, aid, and assist WJVPTPC in procuring all possible insurance benefits.

**- I also agree to inform WJVPTPC immediately upon receiving notification of an Independent Medical Exam (IME) scheduled on my behalf for my claim.** IF YOUR CLAIM IS DENIED FOR AN IME STATING SERVICES NOTE MEDICALLY NECESSARY YOU WILL BE RESPONSIBLE FOR VISITS NOT COVERED/PAID.

- In the event that I receive a direct payment of any amount due for services rendered, I agree that I will hold such payment in trust for WJVPTPC and I also agree to send such payment to WJVPTPC.

- In the event my No-Fault claim is denied ONLY for maximum benefits used, I understand that WJVPTPC will attempt to collect from my primary insurance, this is NOT a guarantee the primary insurance carrier will cover these services. I understand that regardless of my assigned insurance benefits, I am responsible for the total charges of services rendered not covered by the no-fault insurance carrier or my primary insurance carrier.

Primary Insurance: _____ ID #: _____

Insured's Name: _____ Insurance Telephone: _____

**Assignment of Benefits:**

I hereby assign and transfer William Joseph VanVynck, Physical Therapy, PC (WJVPTPC) all my rights, titles and benefits payable by my insurance carrier for services performed by WJVPTPC and its clinicians. I hereby authorize WJVPTPC to submit claims to my insurance carrier or intermediary for all services rendered by our facility and to exercise any appeals and other rights under my policy on my behalf.

THE UNDERSIGNED HAS READ AND UNDERSTANDS THE ABOVE-MENTIONED TERMS

_____

Patient Name (Signature) Date

**Huntington**: 175 E Main Street, Suite 110 Huntington, NY 11743 (631) 427-7600
**Northport**: 10 Fort Salonga Road, Suite 2A Northport, NY 11768 (631) 343-9194