Atlantic Rehabilitation, Inc.

5026-B North Federal Highway

Lighthouse Point, FL 33064

Phone: 954-426-8884 Fax: 954-426-8885

Patient Name: ____ Date: ______________________

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

Atlantic Rehabilitation, Inc.

5026-B North Federal Highway

Lighthouse Point, FL 33064

Or

If my current policy prohibits direct payment to doctor, I hereby also instruct and direct you to make out the check to me and mail it as follows:

5026-B North Federal Highway

Lighthouse Point, FL 33064

For the professional or medical expense benefits allowable and otherwise payable to me under mu 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 also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize Atlantic Rehabilitation, Inc. to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Signature of Policyholder: _____________________________________ Witness: _________________

Signature of Claimant, if other that Policyholder: ____