AUTHORIZATION & ASSIGNMENT

In consideration for your undertaking to care for me, I agree to the following:
You are hereby authorized to release any information you deem appropriate concerning my physical condition to my insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred.
1. I authorize the direct payment to you of any sum I now or hereafter owe you, by my attorney out of the proceeds of any settlement of my case, and/or by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.

2. In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent date) and authorize you to prosecute and action in my name as you see fit and further authorize you to compromise, settle, or otherwise receive and claim as you see fit. I understand that whatever amounts you do not collect from any insurance company proceeds, whether it is all or part of what is due, I personally owe and agree to pay you.

3. In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in this State of Virginia.

4. I agree to pay a fee of $30.00 in the event I cancel WITHOUT 24 hours notice or in the event I NO SHOW for my appointment.

5. I further agree that this Authorization and Assignment is irrevocable and on going until all monies owed are paid in full to:

Fusion Physical Therapy
4701 Spotsylvania Pkwy Ste 106
Fredericksburg, VA 22407

6. This Authorization and Assignment will be in continual effect until revoked by both parties.

Signature ________________________ Date __________________