

AUTHORIZATION AND ASSIGNMENT

Patient's Name: _____ Date of Injury _____

Date of Birth _____

This is to authorize Complete Physical Therapy LLC to disclose and/or furnish to my attorney(s) listed below any and all medical information related to the injury date stated above.

I also assign Complete Physical Therapy LLC and authorize and direct said attorney(s) to pay from the proceeds of any recovery in my case, whether by settlement, compromise, or judgment, all fees for services provided by Complete Physical Therapy LLC as a result of the above-mentioned injury and which are still outstanding at the time of settlement. I understand signing of this form does not prohibit customary billing by Complete Physical Therapy LLC, nor does it relieve me of my personal primary obligation to pay for services provided to me when payment for such services is normally due to Complete Physical Therapy LLC, nor does it limit any other right to a legal remedy that Complete Physical Therapy LLC may have for failure to make such payment.

- Any PIP benefits paid directly to me or my attorney(s) for services rendered by Complete Physical Therapy LLC will be forwarded to Complete Physical Therapy LLC within five days.
- Should my PIP benefits become exhausted or denied I will pay, at time of service any co-insurance amounts due if my personal health insurance is billed.

I understand that the statute of limitation in the state of Maryland is (3) years from the time of the last provided services and that because of long delay in trial dockets many cases are not tried or settled until a date beyond that statute. In view of this, I hereby agree that the three (3) year statute of limitations with respect to any claim for services mentioned above will not begin to run until there is a denial in writing of balance claimed to be due and owing to Complete Physical Therapy LLC by me.

Patient's
Name _____
Signature _____

Clinic
Director _____
Signature _____

Attorney _____
Signature _____

The undersigned attorney agrees to comply fully with this foregoing letter of protection and further agrees to advise the status of the claim within ten (10) days of the request and also agrees to notify Complete Physical Therapy LLC within ten (10) days if the attorney ceased to represent the patient, the claim is dropped or denied, and when the claim is settled or judgment entered.

Date _____
Signature _____