

Boulet Physical Therapy & Wellness Institute

Relieving your pain • Restoring your movement

Insurance Information

Patient Name: _____ Name of Primary Insured: _____

Primary Insured DOB: _____ Primary Insured Employer: _____

Primary Insured Occupation: _____ Group #: _____

SS#/Contract ID #: _____

I hereby instruct and direct _____ Insurance Company/Attorney to pay by check made out and mailed to:

Boulet Physical Therapy and Wellness Institute

Or

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

**C/O Boulet Physical Therapy and Wellness Institute
P O Box 80764
Lafayette, LA 70598-0764**

For the professional or medical expense benefits allowable, and otherwise payable to me under my 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 Boulet Physical Therapy and Wellness Institute to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Patient Signature: _____

Witness: _____

Please Print Name: _____

Date: _____