ROLLING HILLS
Rehabilitation Center

Patient Name: _____

Medicare Number: _____ **Medicaid Number:** _____

Other Insurance Policy: Policy Holder Name: _____

Relationship: _____ **Policy Number:** _____ **Group Number:** _____

Except where my health care benefits plan(s) provides for automatic payment of benefits to the provider of services, I authorize payment of benefits, otherwise, payable to me, for services rendered by the health care provider described above.

I understand that I am fully responsible to the provider for all charges not covered or paid by my health care benefit plan. I further understand that the provider may require that the estimated non-covered charges be paid prior to the completion of an insurance bill or claim.

Until notified in writing, by me, this Assignment of Benefits is to remain valid and in force for the health care provider described above and/or as indicated on the enclosed bill or claim.

Patient Signature: _____ **Date:** _____

Legal Representative if not signed by patient: _____

Relationship: _____ **Date:** _____

RELEASE OF INFORMATION

I authorize this provider to release any clinical and/or financial data necessary to process the claims for the services I have received or will receive in the future from this provider.

Until notified in writing, by me, this Assignment of Benefits is to remain valid and in force for the health care provider described above and/or as indicated on the enclosed bill or claim.

Patient Signature: _____ **Date:** _____

Legal Representative if not signed by patient: _____

Relationship: _____ **Date:** _____

Gmb 8/30/02