DOUGLAS RAPID REHAB, P.A.
4140 N.W. 12TH STREET
LAUDERHILL, FL 33313
TOLL FREE: 1.877.777.8040

DBLI 02_REV 7/8/14

INSTRUCTION FOR DIRECT PAYMENT TO PROVIDER

_____
INSURANCE CARRIER

_____
ADDRESS

_____
CITY, STATE, ZIP

RE: _____

D/A: _____

CLAIM/POLICY: _____

I HEREBY INSTRUCT AND DIRECT THE **DOUGLAS RAPID REHAB, P.A.** INSURANCE COMPANY TO PAY THE PROFESSIONAL AND MEDICAL EXPENSE BENEFITS ALLOWABLE AND OTHERWISE PAYABLE UNDER MY CURRENT INSURANCE POLICY FOR SERVICES RENDERED BY **DOUGLAS RAPID REHAB, P.A.** BY CHECK MADE OUT AND MAILED DIRECTLY TO:

DOUGLAS RAPID REHAB, P.A.
4140 N.W. 12TH STREET
LAUDERHILL, FL 33313

IF MY CURRENT POLICY PROHIBITS DIRECT PAYMENT TO THE DOCTOR, THEN I HEREBY ALSO INSTRUCT AND DIRECT YOU TO MAKE OUT THE CHECK TO ME FOR PROFESSIONAL AND MEDICAL EXPENSES RENDERED BY **DOUGLAS RAPID REHAB, P.A.** AND MAIL IT AS FOLLOWS:

DOUGLAS RAPID REHAB, P.A.
4140 N.W. 12TH STREET
LAUDERHILL, FL 33313

AS PAYMENT TOWARD THE TOTAL CHARGES FOR PROFESSIONAL SERVICES RENDERED. I UNDERSTAND AND AGREE THAT I AM PERSONALLY RESPONSIBLE FOR AND/ALL BALANCES OVER AND BEYOND WHAT MY INSURANCE CARRIER PAYS FOR SERVICES RENDERED BY **DOUGLAS RAPID REHAB, P.A.**.

THIS IS NOT A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

I ALSO AUHORIZE THE RELEASE OF ANY INFORMATION REGARDING PAYMENT OF MEDICAL EXPENSES TO ANY INSURANCE COMPANY, ADJUSTER OR ATTORNEY INVOLVED IN THIS CASE.

DATED AT: _____ THIS_____ DAY OF _____ 20_____

PATIENT SIGNATURE: _____ WITNESS: _____

_____
SIGNATURE OF POLICYHOLDER, IF OTHER THAN PATIENT