PHYSICAL THERAPY ASSOCIATES OF MERCER COUNTY, P.C.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTIES.

I,_________________________________(print name) have reviewed a copy of Physical Therapy Associates of Mercer County's Notice of Privacy Practices.

SIGNED:_____________________________ _____________________
(patient or personal representative) (date)

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(relationship to patient)

ASSIGNMENT OF BENEFITS

I, __________________________________, (print name) request that payment of authorized benefits be made directly to PHYSICAL THERAPY ASSOCIATES OF MERCER COUNTY, INC. I fully understand that I am solely responsible for all charges incurred. If said charges are not paid, I am responsible for payment in full at that time. I further understand that I will be responsible for any additional charges, such as interest, court costs and attorney fees, should they become necessary for the collection of these services. I specifically assign and transfer to PHYSICAL THERAPY ASSOCIATES OF MERCER COUNTY, INC. all of my rights, benefits, and causes of action, in order to collect medical and/or PIP benefits from my insurance company. I hereby authorize PHYSICAL THERAPY ASSOCIATES OF MERCER COUNTY, INC. to file a PIP action, either in superior court or with the National Arbitration Forum, with respect to any unpaid bills, and to authorize PHYSICAL THERAPY ASSOCIATES OF MERCER COUNTY, INC. to name itself in any such actions, This lifetime authorization is effective with the date of the signing. I may revoke this authorization by notifying PHYSICAL THERAPY ASSOCIATES OF MERCER COUNTY, INC. in writing.

SIGNED:_________________________________ _____________________
(patient or personal representative) (date)

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(relationship to patient)