RIVERGARDEN | Rehab
PERSONALIZED CARE WITH EXCEPTIONAL RESULTS

INSURANCE BILLING

I certify that the information given by me in applying for payment is, to the best of my knowledge, true and correct. I hereby authorize release to the insurance company, or its intermediaries or carriers, any information needed for this or a related claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for institutional or physician services to the physician or organization furnishing the services or authorize such organization or physician to submit a claim to the below insurance company or payment on my behalf. This also applies to ancillary services.

_____ _____

Insurance Company *Policy #*

_____ _____

Client or Health Care Surrogate's Signature *Date*