www.lymphatx.com

BOCA RATON
Delmar Office Park
7301 W Palmetto Park Rd,101C
Boca Raton, Florida 33433
(561) 392-5131

BOYNTON BEACH
Boynton Medical Arts Building
10075 Jog Road, Suite 201
Boynton Beach, Florida 33437
(561) 733-1012

TAMARAC
University Medical Plaza
7301 University Drive, Suite 301
Tamarac, Florida 33321
(954) 752-1500

Patient Consent and Authorization for Insurance Billing

Consent for Treatment

I voluntarily consent to the renderings of care, including treatment. I understand that I am under the care and supervision of the prescribing physician and it is the responsibility of Lymphatx, Inc. to carry out the instructions of such physician (s).

Assignment of Benefits

I hereby assign payment directly to Lymphatx, Inc. and/or therapist accepting the assignment of benefits and applicable charges. I understand that I am financially responsible for the charges not covered by this assignment or for any of other charges which the insurance carrier denies to pay.

It is further agreed that any credit balance resulting from payment of insurance of other sources may be applied to any other accounts owed to Lymphatx, Inc. and/or therapist by the insured or his or her family.

Home Health Care

(Applicable to Medicare and Medicare equivalent Insurances only)

I certify that I am *NOT* presently enrolled in any Home Health Care. Medicare *DOES NOT* pay for skilled home health services at the same time as outpatient therapy. Subsequent rejection of a claim by Medicare will constitute responsibility for payment of claim by me.

Lifetime Authorization
Medicare and Medicaid Patient Certification-Payment Classification
Authorization to Release Information and Payment Request

I certify that the information given by me in applying for payment under title and/title XIX or the social security act is correct: I authorize any holder of medical or other information about me to release to the social security administration or it's intermediary carriers, any information needed for this or a related Medicare, Medicaid, or other third party claim. I request that payment of authorized benefits be made on my behalf I assign the benefits payable for therapy services. I understand that I am responsible for my health insurance deductibles and co-insurance.

Print Name: _____

Signature: _____ **Date** _____

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