





Advanced Physical Therapy Center OF STAMFORD, LLC  
203-359-8326

**ASSIGNMENT & RELEASE:** I authorize direct payment of medical benefits to Advanced Physical Therapy Center of Stamford, LLC, 999 Summer Street, Stamford, CT 06905. I also authorize the therapist and Advanced Physical Therapy Center of Stamford, LLC to release all information necessary to secure the payments of benefits. I authorize this signature on all insurance submissions.

**INSURANCE PAYMENTS:** In the event that your insurance company issues payment directly to you, please endorse the check to "APTC of Stamford LLC" and send it with the Explanation of Benefits to this office immediately. Failure to do will result in you incurring the TOTAL billed amount in addition to legal action.

**ADDITIONAL CHARGES:**

A 1.0% monthly interest charge will be added to any unpaid balances after 30 days.

A \$20.00 fee will be added to all returned checks.

Attorney fees will be charged to resolve any outstanding balances.

**PAYMENT OPTIONS:** We accept CASH, CHECK, MASTERCARD, VISA, AMEX and DINERS CLUB. You must receive a receipt with EVERY cash payment.

**RELEASE OF MEDICAL INFORMATION:** I \_\_\_\_\_ hereby authorize Advanced Physical Therapy Center of Stamford, LLC to release and obtain my medical records regarding my condition which includes, but not limited to history, findings, diagnostic tests, diagnosis, prognosis, casual relationship, office notes or pertinent data. This also authorizes telephonically, voicemail, facsimile, e-mail or electronic data release of current medical and billing pertaining to my condition. I understand and agree that a photocopy of facsimile of this authorization may be accepted to release or obtain information as though it were an original.

\_\_\_\_\_  
Referring Physician

\_\_\_\_\_  
initials

\_\_\_\_\_  
Primary Care Physician

\_\_\_\_\_  
initials

\_\_\_\_\_  
Insurance Carrier

\_\_\_\_\_  
initials

\_\_\_\_\_  
Employer (workers' compensation only)

\_\_\_\_\_  
initials

\_\_\_\_\_  
Attorney (if applicable)

\_\_\_\_\_  
initials

\_\_\_\_\_  
initials

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Guardian Name & Relationship

\_\_\_\_\_  
Guardian Signature

\_\_\_\_\_  
Date