InterPlay
Occupational Therapy for Children

HEALTH INSURANCE
ASSIGNMENT OF BENEFITS

Name of Patient _____ Insurance Company _____

Date of Birth _____ Policy No. _____

Address _____ Group No. _____

Phone _____ Name of Policy Holder _____

I hereby direct the above insurance company to pay to InterPlay, Inc. all medical benefits due me under policy for covered expenses rendered to the patient identified above. Please make check payable to: InterPlay, Inc. and mail to:

14552 Larkspur Lane
Wellington, FL 33414

I understand that this authorization applies to those eligible charges submitted in connection with services or supplies furnished only by and through the above provider.
In addition, I understand that I am responsible for any portion of charges, including any attorney's fees, interest on unpaid balances and all costs of collection resulting from any investigation necessary to collect this claim, not reimbursed through other sources.

*** * INSURANCE COMPANY – IMPORTANT- PLEASE NOTE * ***

Your insured, whose name and signature appear below, has by this Assignment directed you to make payment of all benefits for services provided by InterPlay, Inc. directly to InterPlay, Inc. Should you fail to make payments in accordance with this written Assignment, you will not have discharged yourself from liability under the policy identified above, and your remaining obligation to InterPlay, Inc., to the extent that you have violated the terms of this Assignment, may result in you becoming legally obligated to pay the same benefits twice.

_____ _____
Signature of Policy Holder Date

_____ _____
Witness Date