

Cupertino Physical Therapy, Inc.

ASSIGNMENT OF BENEFITS

Patient's Name: _____

Patient's Identification Number: _____

Primary Insurance Company: _____

Secondary Insurance Company: _____

I hereby authorize, Cupertino Physical Therapy, Inc. and/or Paul A. Murdock, RPT., to furnish to my insurance carrier(s) any and all requested information concerning my health care

I also authorize my insurance carrier(s) to pay Cupertino Physical Therapy, Inc. and/or Paul A. Murdock, RPT, directly for services rendered.

*****Please Note:** As a courtesy for our patients, we gladly verify your insurance. As a member, you are responsible for the knowledge of your own specific plan. The information given to us by a representative of your insurance is not a guarantee and all payments will be the responsibility of the patient.

Signed: _____
(Patient or Legal Guardian)

Date: _____