Performance Therapeutics
Physical Therapy & Sports Medicine

DATE:_____ **PATIENT INSURANCE INFORMATION**

☐ **NEW PATIENT** ☐ **UPDATE**

PATIENT NAME: _____ DOB: _____AGE:_____

ADDRESS: _____

CITY:___ STATE ZIP: GENDER: M◯ F◯

PATIENT'S SS#: _____

PHONE: (_____)_____ 2nd PHONE: (_____)_____

PRIMARY PHYSICIAN_____ PHONE: (_____)_____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

REFERRING PHYSICIAN_____UPIN#_____

ADDRESS: PHONE: (_____) ___
CITY: STATE: ZIP:

RESPONSIBLE PARTY

NAME: _____ SS#: _____
ADDRESS: PHONE: (_____)_____
CITY: _____ STATE: _____ ZIP:_____

EMPLOYMENT INFORMATION

EMPLOYER NAME: ___ ____ PHONE: (_ _)__ ___
ADDRESS:__ CITY: _
STATE:_____ZIP:_____ RELATIONSHIP TO PATIENT:_____

PRIMARY INSURANCE

INSURANCE NAME: _____
ADDRESS: _____ PHONE: (_____)_____
CITY: _____ STATE: _____ ZIP: _____
POLICY#: GROUP #: _____
INSURED NAME: INSURED SS#: _____
INSURED EMPLOYER: _____ INSURED DOB:

HAVE YOU EVER HAD HOME HEALTH SERVICES? EXAMPLES: *Nursing, Woundcare, Vital Signs, Sugar checked.*

☐ **YES (if checked speak with Receptionist!!!)** ☐ **NO**

NAME: DATES OF SERVICE:

ADDRESS: _____ PHONE: (_ ___)__ _____

CITY: _____ STATE: _____ ZIP:_____

Performance Therapeutics
Physical Therapy & Sports Medicine

Welcome to Performance Therapeutics! Please fill out the following information:
Bienvenidos a Performance Therapeutics! Por favor llenar las sigientes preguntas:

MEDICAL HISTORY
HISTORIA MEDICA

Date:
Fecha:_____

Date of Injury:
Fecha de lastimadura:_____

ABOUT YOUR CURRENT INJURY
INFORMACION ACERCA DE SU LASTIMADURA ATUAL:

1. **Which of the following activities are difficult?**
Cual de las siguientes actividades se le dificultan?

☐	**Sleeping**/Dormir	☐	**Getting out of bed**/Levantarse de la cama	☐	**Dressing: _shirt _shoes _pants** Vestirse: _camisa _zapatos _pantalones
☐	**Getting in/out of tub or shower** Entrar/Salir de la Bañera	☐	**Retrieving wallet from back pocket** Sacar la Billetera de la bolsa trasera	☐	**Fastening-unhooking bra** Abrochar/ Desabrochar el Sosten
☐	**Walking: _minutes or _feet** Caminar: _minutos _pies	☐	**Walking up stairs/steps** Subir Escaleras/Escalones	☐	**Walking down stairs/steps** Bajar Escaleras/Escalones
☐	**Sitting; _minutes** Sentarse: _minutos	☐	**Bending over**/Agacharse	☐	**Lifting a gallon of milk** Levantar un Galon de leche
☐	**Getting in/out of car** Entrar/salir de el carro	☐	**Driving**/Manejar	☐	**Reaching above into cabinet** Alcanzar algo en un Gabinete alto
☐	**Arising from sitting** Ponerse de pie	☐	**Holding objects**/Agarrar Objetos	☐	**Opening jars/cans** Abrir Jarras/ Botes

2. **What activity makes your condition worse?**
Que Actividad empeora su condicion

_____

3. **What activity makes your condition better?**
Que Actividad mejora su condicion

_____

4. **How were you injured?**
*Como se lastimo?*_____

5. **Have you had any special tests such as MRI, X-RAYS, etc?**
Ha tenido algun Estudio Especial Como Resonancia Magnetica, Rayos X, Etc _No

6. Where is your injury or area(s) of pain? Please check
Donde esta su lastimadura o Area(s) de dolor? Por favor marque

	Right side Lado Derecho	**Left side** Lado Izquierdo	**Both sides** Ambos Lados
Neck/ Nuca	☐	☐	☐
Shoulder/ Hombros	☐	☐	☐
Elbow/Codo	☐	☐	☐
Upper arm/Ante Brazo	☐	☐	☐
Lower arm/Bajo Brazo	☐	☐	☐
Wrist/Muñeca	☐	☐	☐
Hand-fingers/Mano-dedos	☐	☐	☐
Upper back/Espalda Superior	☐	☐	☐
Lower back/Espalda Baja	☐	☐	☐
Pelvis-hip/Cadera	☐	☐	☐
Buttocks/Sentaderas	☐	☐	☐
Upper leg/Muslos	☐	☐	☐
Knee/Rodilla	☐	☐	☐
Lower leg/Chamorros	☐	☐	☐
Ankle/Tobillo	☐	☐	☐
Foot/Pie	☐	☐	☐

7. How much pain do you have? Please check
Cuanto dolor tiene? Por favor marque

No activity Sin actividad	**Pain scale** Escala de Dolor	**W/activity** Con Actividad
	Scale of 1 to 10 Escala de 1 al 10	
○ 0	**No pain present** Sin Dolor Presente	○ 0
○ 1	**Minimal** / Minimo	○ 1
○ 2	**Mild (just enough to notice)** Menor (apenas se siente)	○ 2
○ 3		○ 3
○ 4		○ 4
○ 5	**Moderate (I am aware but can function** Moderado(lo siento pero puedo soportarlo	○ 5
○ 6		○ 6
○ 7		○ 7
○ 8	**Intense/**Intenso	○ 8
○ 9	**Severe(all activities are significantly affected)** Severo	○ 9
○ 10	**Have to go to Hospital** Necesidad de Hospitalizacion	○ 10

8. Are you on medication? Please list:
Esta usted tomando medicinas? Por favor Enlistelas:_____

_____

_____

MEDICAL HISTORY (CONTINUED)
Historia Medica

9. Please list surgeries and current medical conditions such as Allergies, diabetes, high blood pressures, arthritis, others:
Por favor enliste Cirugias y condiciones medicas actuales como alergias, diabetes, Hipertension Arterial, Artritis, otras:_____

10. Do you have artificial implants such as a total knee or hip replacement, spinal fusion, etc?
No
Tiene usted algun Implante Artificial como de Rodilla, Cadera, ofusion Espinal, Etc? No

11. Are you or think you may be pregnant? No
If no, then by signing below, you certify that you are not pregnant and do not plan to get pregnant in the next 5 weeks. If you speculate that you may be pregnant during the course of treatment you will notify the physical therapist.

***X*_____**
Patient Signature

Esta usted o piensa estar Embarazada? Yes
Si no , Entonces al firmar abajo, Usted certifica que no esta embarazada y no planea quedar embarazada en las proximas 5 semanas. Si usted sospecha que esta embarazada durante el curso de el tratamiento debe notificar a su Fisico-Terapeuta.

*X*_____
Firma de el Paciente

GENERAL INFORMATION:
Informacion General:

12. Living situation:
Condiciones De Vida:

☐ **Live alone** *Vive Solo(a)* **Live with family member/other:** *Vive con miembro de familia/otro*:_____

☐ **House** *Casa* ☐ **mobile home** *Casa Mobil*

☐ **Apartment** *Departamento* **Other** *Otro:* _____

Stairs/steps?: No **Ramp?:** No **railing:** No
Escaleras/Escalones: No *Otro equipo adaptativo especial en su casa:* No

13. What is your occupation?
Cual es su ocupacion?

Are you currently working? No **Where:**
Esta usted trabando actualmente? No *Donde?*

_____ _____

Performance Therapeutics
Physical Therapy & Sports Medicine

PATIENT THERAPY CONTRACT
CONTRATO DE TERAPIA DEL PACIENTE

PERFORMANCE THERAPEUTICS, LLC IS DEDICATED TO PROVIDING QUALITY REHABILITATION SERVICES TO ALL PATIENTS. A POLICY HAS BEEN IMPLEMENTED IN ORDER TO MAXIMIZE PROGRESS, AS WELL AS TO ACHIEVE THE PROGRAM'S AND PATIENT'S GOALS.
EL CENTRO DE REHABILITACION PERFORMANCE THERAPEUTICS, LLC SE DEDICA A PROPORCIONAR SERVICIOS DE CALIDAD A TODOS LOS PACIENTES. SE HA FORMULADO UNA NUEVA POLIZA PARA MEJORAR A LO MAXIMO EL PROGRESO DEL PACIENTE Y ASI PODER ALCANZAR LAS METAS FIJADAS EN LA TERAPIA.

AS A PATIENT OR PARENT/GUARDIAN OF PATIENT, I AGREE THAT:
COMO PACIENTE O PADRE/FAMILIAR DEL PACIENTE, YO:

1. I will give at least 24 hours notice if unable to make scheduled appointment. If 24 hours is not possible I will call to inform of cancellation prior to therapy session. Entiendo que dare 24 horas de anticipacion si no puede mi nino(a) mantener la cita, y en caso que no sea possible, llamare para su cancelacion antes del tiempo de la session de terapia.

2. I understand it is very important to be punctual with my appointment time. Tardiness can result in cancellation of therapy session. Entiendo que es muy importante ser puntual con la cita llegar tarde puede dar como rsultado en cancelacion de la session de terapia.

3. I understand that after 3 CONSECUTIVE "NO SHOWS" my child is subject to dismissal from therapy Immediately. Entiendo que despues de 3 CONSECUTIVAS "CANCELACIONES" mi nino(a) puede ser dado de alta o los servicios seran cancelados completamente de imediato.

4. I understand my child's attendance to therapy must be consistent in order to maximize progress. entientdo que la asistencia de mi nino(a) debe ser constante para poder llegar a desarrollar el maximo progrsso.

5. I understand my child cannot attend therapy if he/she has an infection or contagious disease (example: Fever, Chicken Pox, Measles, Thrush, Impetigo, Pink Eye, Strep, Hepatitis, etc). entiendo que mi nino(a) no puede atender a la terapia si el/ella tiene alguna infeccion of enfermedad contagiosa (Ejemplo: Fiebre, Varicela, Sarampion, Infecciones en la piel, Mal de ojo Hepatitis, Algodancillo, Etc.)

6. If there is a change in my phone number and/or address, I will inform PERFORMANCE THERAPEUTICS of the change immediately. Si hay algun cambio en mi numero telefonico o en el domicilio, yo le informare ha PERFORMANCE THERAPEUTICS.

7. I UNDERSTAND THAT FOR THE SAFETY OF MY CHILD, AN ADULT MUST REMAIN IN THE FACILITY WHILE MY CHILD IS IN SESSION. NO EXCEPTIONS! ENTIENDO QUE PARA LA SEGURIDAD DE NINO(A). SE REQUIERE QUE UN ADULTO ESTE PRESENTE DURANTE LA SECION DE TERAPIA NO HAY EXCEPCIONES!

Patient/Guardian Signature _____ Date _____ Therapist's Signature _____ Date _____

Performance Therapeutics
Physical Therapy & Sports Medicine

PATIENT'S NAME: _____

Performance Therapeutics is a provider of rehabilitation service including: Physical Therapy, Occupational Therapy Speech Language Pathology in its free standing clinic.

CONSENT TO TREAT

The patient is under the control of his physician and the undersigned consents to any treatment or procedures rendered the patient by the agency under the general and specific instructions of the physician it is further understood that the agency is authorized to carry out all instructions of the patient's doctor and that the agency is hereby relieved of any and all liability occurring from the performance of the doctor's instructions.

I request and authorize the staff of Performance Therapeutics to provide me with the treatment and to perform any procedures now contemplated or such additional procedures as my doctor may deem reasonable and necessary.

I authorize my insurance company to disclose information regarding my medical coverage, but not limited to verification of my insurance number, effective dates and type of coverage.

The undersigned certifies that he/she has read the foregoing and is the patient, or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms. It is further understood that this release remains in effect for one (1) year unless otherwise revoked.

_____ _____
Patient's Signature Witness

_____ _____ Date: _____
Signature of Person Authorized to Sign in Lieu of Patient Relationship to Patient

FINANCIAL RESPONSIBILITY

I hereby accept all responsibility for treatment costs not covered or reimbursed by third party payers. The undersigned Certifies that he/she has been explained the treatment costs and is the responsible party and accepts these terms.

_____ _____ _____
Responsible Party and/or Trustee of Patient's funds Date Witness

RELEASE OF INFORMATION: The agency may disclose all or any part of the patient's record to any person or corporation which is involved in the plan of care or may be liable under a contract to the agency or to the patient or to a family member. The agency may disclose whether in writing or by oral communication any or all of the patient's record.

I hereby authorize:

Performance Therapeutics,LLC

Request medical information from the medical record(s) of:

Patient's Name:_____
Date:_____
Patient's DOB:_____
SS#:_____

Information to be requested:

☐ Evaluation ☐ X-ray report ☐ MRI report
☐ Progress Notes from_____ to _____ dates
☐ Other:_____

I understand this consent can be revoked at any time to the extent that the disclosure made in good faith has already occurred in reliance on this consent. The facility, its employees and officers and attending therapist are released from legal responsibility of liability for the release of the above information to the extent indicated and authorized herin.

Signature:_____ Date:_____
Patient or Representative

Relationship to Patient:_____

Witness:_____

500 EAST LINDBERG AVE. MCALLEN, TX 78501
PHONE (956) 687-4555

ATTENTION

AFTER 3 MISSED APPOINTMENTS,
A **"NO SHOW"** LETTER WILL BE SENT TO YOUR DOCTOR. THIS LETTER DESCRIBES NON-COMPLIANCE WITH DOCTORS ORDERS.

AFTER 6 MISSED APPOINTMENTS, PATIENTS WILL BE DISCHARGED FROM PHYSICAL THERAPY.

YOUR DOCTOR WILL BE INFORMED. PLEASE BE ADVISED. NON COMPLIANCE MAY INTERFER WITH PAYMENTS, CASE REVIEWS, AND OUTCOMES.

"THE LESS YOU MISS THE FASTER YOU GET BETTER"

Patient Signature _____

Performance Therapeutics
Physical Therapy & Sports Medicine

500 Lindberg Ave
McAllen, Texas 78501
Phone: 956.687.4559
Fax: 956.687.4554

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION EFFECTIVE DATE: SEPTEMBER 15, 2003. PLEASE REVIEW IT CAREFULLY

If you or your caregiver has any questions about this notice, please contact Omar Palomin, HIPAA Compliance officer at (956) 687-4555.

This notice describes our privacy practices. Performance Therapeutics may share health information with each other for treatment, payment, or health care operations purposes described in this notice.

OUR PLEDGE REGARDING HEALTH INFORMATION:

We understand that health information about you is personal. We are committed to protecting health information about you. We create a record of the care and services that you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this health care practice, whether made by your therapist or others working in this office. This notice will tell you or your caregiver about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

- Make sure that health information that identifies you is kept private;
- give you or your caregiver this notice of our legal duties and privacy practices with respect to health information about you;
- follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU.

The following categories describe different ways that we use and disclose health information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment: We may use health information about you to provide you with health care treatment or services. We may disclose health information about you to doctors, nurses, student interns, or other personnel who are involved in taking care of you. They may work at our offices, at a doctor's office, or other health care providers to whom we may refer you for consultation.

For Payment: We may use and disclose health information about you so that the treatment and services you receive from us may be billed to and payment collected from you, an insurance company, or a third party.

For health Care Operations: We may use and disclose health information about you for operations of our clinics. These uses and disclosures are necessary to run our practice and make sure that all of our patients receive quality care.

Appointment Reminders: We may use and disclose health information to contact you as a reminder that you have an appointment. Please let us know if you do not wish to have us contact you concerning your appointment or if you wish to have us use a different telephone number or address to contact you for this purpose.

As Required By Law. We will disclose health information about you when required to do so by federal, state, or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Public Health Risks. We may disclose health information about you for public health activities. These activities generally include the following:

- to prevent or control disease, injury or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify person or organization required to receive information on FDA-regulated products;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release health information if asked to do so by a law enforcement official:

- in reporting certain injuries, as required by law, gunshot wounds, burns, injuries to perpetrators of crime;
- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person:
    - name and address
    - Date of birth or place of birth;
    - Social security number;
    - Blood type or rh factor;
    - Type of injury;

-
- Date and time of treatment and/or death, if applicable; and
- A description of distinguishing physical characteristics about the victim of a crime, if the victim agrees to disclosure or under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct at our facility; and
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description, or location of the person who committed the crime.

Coroners, Health Examiners and Funeral Directors. We may release health information to a coroner or health examiner. We may also release health information about patients to funeral directors as necessary to carry out their duties.

National Security an intelligence Activities. We may release health information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law. We may also disclose health information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

Research. In limited circumstances, we may use and disclose your personal health information for research purpose. For example, a research organization may wish to compare outcomes of all patients that receive a piece of medical equipment and will need to review of series of medical records. In cases where your specific authorization has not been obtained, your privacy will be protected by strict confidentiality requirements applied by an institutional Review Board or privacy board which oversees the research or by reprentation of the researchers that limit their use and disclosure of patient information.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

YOU HAVE THE FOLLOWING RIGHTS REGARDING HEALTH INFORMATION WE MAINTAIN ABOUT YOU:

Right to Inspect and Copy: You have the right to inspect and copy health information that may be used to make decisions about your care. Usually, this includes health and billing records. To inspect and copy health information that may be used to make decisions about you, you must submit your request in writing to Omar Palomin HIPAA Compliance. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies and services associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. Another licensed health care professional chosen by our practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend. If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as we keep the information. To request an amendment, your request must be made in writing, submitted to Omar Palomin HIPAA Compliance Officer, and must be contained on one page of paper legibly handwritten or typed. In addition, you must provide a reason that supports your request for an amendment. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the health information kept by or for our practice;
- is not part of the information which you would be permitted to inspect and copy; or
- is accurate and complete.

Any amendment we make to your health information will be disclosed to those with whom we disclose information as previously specified.

Right to an Accounting of Disclosures. You have the right to request a list accounting for any disclosures of your health information we have made, except for uses and disclosures for treatment, payment, and health care operations, as previously described. To request this list of disclosures, you must submit your request in writing to Omar Palomin HIPAA Compliance Officer. Your request must state a time period which may not be longer than six-years. The first list you request within a 12 month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may chose to withdraw or modify your request at that time before any costs are incurred. We will mail you a list of disclosures in paper form within 30 days of your request, or notify you if we are unable to supply the list within that time period and by what date we can supply the list; but this date will not exceed a total of 60 days from the date you made the request.

Right to Request Restrictions. You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we restrict a specified nurse from use of your information, or that we not disclose information to your spouse about a surgery you had. We are not required to agree to your request for restrictions if it is not feasible for us to ensure our compliance or believe it will negatively impact the care we may provide you.

Right to Request Confidential Communications. You have the right to request that we communicate with you about health matters in a certain way or at a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail to a post office box. To request confidential communications, you must make your request in writing to Omar Palomin HIPAA Compliance Officer. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice. You have the right to obtain a paper copy of this notice at any time. To obtain a copy, please request it from Omar Palomin HIPAA Compliance Officer.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our facility. The notice will contain on the first page, the effective date. In addition, each time you register for treatment or health care services, we will offer you a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us, contact Omar Palomin HIPAA Compliance Officer. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

OTHER USES OF HEALTH INFORMATION.

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Acknowledgement of Receipt of this Notice

We will request that you sign a separate form or notice acknowledging you have received a copy of this notice. If you choose, or are not able to sign, a staff member will sign their name, date. This acknowledgement will be filed with your records.

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, have received the Notice of Privacy Practices from Performance Therapeutics

ڤ Check here if you have received this on behalf of a child

Sign:_____ Date:_____

In lieu of patient signature, I,_____, a staff member of Performance Therapeutics state that _____ has been given our current Notice of Privacy Practices.

Sign:_____ Date:_____

PLEASE REMOVE THIS PAGE AFTER SIGNING AND RETURN IT TO THE FRONT OFFICE

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO HEALTH PROVIDER

Patient: _____

Address: _____

City: _____ State: _____ Zip:_____

Insurance Company: _____

Claim or Group #: _____

SS# or State ID #:_____

I hereby instruct the above named Insurance Company to pay by check made out to and mailed directly to:

Performance Therapeutics
500 Lindberg Ave.
McAllen, TX 78501

for professional or medical expense allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY**. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to payment in a current manner, any balance of said professional fees for non-covered services and / or fees, over and above the insurance payment or as required by my insurance policy.

A photocopy of this Assignment shall be considered effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney for the purpose of securing payment under this policy of insurance.

Dated at _____ County, this_____day of _____20_____

_____ _____

Signature of Policy Holder **Witness**

_____

Signature of Claimant, if other than Policyholder

Submit Form