

**SKYLINE PHYSICAL THERAPY SERVICES**  
**13911 GOLD CIRCLE SUITE 110**  
**OMAHA, NE 68144**  
**(402) 333-8464**

Date \_\_\_\_\_

Patient: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Claim Group: \_\_\_\_\_  
SS# / ID#: \_\_\_\_\_

I hereby instruct and direct \_\_\_\_\_ Insurance Company to pay by check made out and mailed to:

**SKYLINE PHYSICAL THERAPY SERVICES**  
**13911 GOLD CIRCLE SUITE 110**  
**OMAHA, NE 68144**

or

If my current policy prohibits direct payment to doctor, I hereby also instruct and direct you to make out the check to me and mail it as follows:

**SKYLINE PHYSICAL THERAPY SERVICES**  
**13911 GOLD CIRCLE SUITE 110**  
**OMAHA, NE 68144**

for the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the 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 pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as 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 involved in this case.

I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Dated at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

\_\_\_\_\_  
Signature of Policyholder

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Signature of Claimant, if other than Policyholder