

Therapy Unlimited, LLC

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AUTHORIZATION ASSIGNMENT/CONSENSUAL LIEN

PLEASE BE ADVISED that pursuant to MCL 500.3112, Therapy Unlimited, LLC hereby exercises the right to claim a lien on benefits payable to or for the benefit of the undersigned patient, and in accordance with the aforementioned statute, the undersigned patient's insurance carrier is directed to issue payments for bills submitted by Therapy Unlimited, LLC directly to this office. In addition, any settlement reached by the undersigned patient with any party, claimant or provider other than Therapy Unlimited, LLC is in no way binding upon, and in no way bars any claims asserted by Therapy Unlimited, LLC.

TO: THERAPY UNLIMITED, LLC

In consideration of your undertaking to treat me, I agree to the following:

AUTHORIZATION TO RELEASE INFORMATION

You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster, in order to process any claim and reimbursement of charges incurred by me as a result of professional services rendered by you, and I hereby release you of any consequence thereof.

ASSIGNMENT OF CAUSE OF ACTION

In the event any insurance company is obligated by contractual agreement to make payment to me or to you for services rendered by Therapy Unlimited, LLC, I hereby assign and transfer to you the cause of action that exists in my favor against any such company to the extent of said services, plus lien costs of collection and interest, and authorize you to compromise, settle or otherwise resolve said claim as you see fit as my attorney-in-fact. I understand that whatever amounts you do not collect from insurance proceeds (whether it be all or part of what is due), I will personally owe you and agree to pay in a current manner.

AUTHORIZATION TO PAY DIRECTLY TO THERAPY UNLIMITED, LLC

In consideration of the physical therapy services rendered and to be rendered to me, I authorize and direct the payment to Therapy Unlimited, LLC, and only Therapy Unlimited, LLC, of any sum I now or hereafter owe you out of the proceeds of any settlement of my case and/or by any insurance company obligated to reimburse me for the charges for your services.

ACKNOWLEDGEMENT AND UNDERSTANDING

I acknowledge and understand that Therapy Unlimited, LLC will submit its billing to my insurance carrier, if any. However, in the event that my insurance carrier either refuses to acknowledge the obligation owing to Therapy Unlimited, LLC or in the event that payment of the submission is not made by my insurance carrier within thirty (30) days of submission, then I will agree to make payment to Therapy Unlimited, LLC on a current basis.

CONSENSUAL LIEN

I hereby grant a consensual lien to Therapy Unlimited, LLC (a) in and to any and all insurance proceeds payable to me arising from any claim for reimbursement or recovery for the services rendered to me by Therapy Unlimited, LLC, and (b) in and to any and all proceeds derived from any litigation to recover damages, which include the cost of services rendered to me by Therapy Unlimited, LLC. In that regard, Therapy Unlimited, LLC may file a copy of this Agreement with the Uniform Commercial Code Division of the Secretary of State in Lansing, Michigan, and with any insurance carrier or court to perfect its lien as aforesaid.

IN WITNESS WHEREOF, the undersigned has executed this Agreement in favor of Therapy Unlimited, LLC as of the ____ day of _____, 20__.

WITNESS:

Patient's Signature
Social Security No. _____