21-14 Newtown Avenue
First Floor
Astoria, NY, 11102
Tel: 718.545.0958

## RELEASE OF INFORMATION

I permit LEAPS AND BOUNDS PHYSICAL THERAPY AND OCCUPATIONAL THERAPY, PLLC to disclose all, or part of the (name) ___________________________________ medical records to any person, corporation or agency when required for the collection of benefits or payment of LEAPS AND BOUNDS PHYSICAL THERAPY AND OCCUPATIONAL THERAPY, PLLC charges.

## GUARANTEE OF ACCOUNT

For and in accordance of services rendered to above named person by LEAPS AND BOUNDS PHYSICAL THERAPY AND OCCUPATIONAL THERAPY, PLLC hereby agree to pay the full bill for coverage which are not paid to the LEAPS AND BOUNDS PHYSICAL THERAPY AND OCCUPATIONAL THERAPY, PLLC by third party payers or any balance due which not covered by third party payers or excluded by third party payers clause.

## ASSINGMENT OF BENEFITS

I assigned all benefits from any corporation, agency, person or other third party payer to LEAPS AND BOUNDS PHYSICAL THERAPY AND OCCUPATIONAL THERAPY, PLLC for services rendered. Additionally, I authorized payments to these benefits directly to LEAPS AND BOUNDS PHYSICAL THERAPY AND OCCUPATIONAL THERAPY, PLLC.

In signing this document I hereby affirm that I have read and fully understand above statements.

Parent or Guardian Signature: ____________________________ Date: ________________

Patient Signature: _______________________________________ Date: _____________

Signer's Name: _____________________________________

Address: _____________________________________
_____________________________________
_____________________________________

Phone #: _____________________________________