

# Capitol Rehab, Inc.

801 N. Quincy Street  
Suite 130  
Arlington, VA 22203  
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I, \_\_\_\_\_, hereby authorize Capitol Rehab to apply for benefits on my behalf for covered services rendered. I request payment from \_\_\_\_\_ insurance company, to be made directly to the above-named provider.

I certify that the information I have reported with regard to my insurance coverage to be correct and further authorize the release of any necessary information, including medical information for this or any related claim, to the above-named billing agent, and/or insurance company named above. I permit a copy of this authorization to be used in place of the original. Either the above-named carrier or myself may revoke this at any time in writing.

Our payment policy is to collect the patient's portion at the time services are rendered. Whether or not your insurance company pays in full, a portion, or no portion of your medical bills is a matter between you and your insurance carrier. Unless other arrangements have been made, any unpaid balances are due within 30 days of treatment. Payment is accepted in the form of cash, check, Money Order, Visa, Mastercard, Discover, or American Express.

If I fail to meet my financial commitment to Capitol Rehab and it becomes necessary to take action to collect my account, I agree to pay all costs and expenses incurred in the collection of my account, including attorney's fees and collection agency fees.

I understand that Capitol Rehab will call my insurance carrier and tell me my insurance benefits as a courtesy. I will not hold Capitol Rehab responsible for any misinformation my insurance company may give them.

Signature \_\_\_\_\_ Date \_\_\_\_\_