

**COLUMBIA REHABILITATION CLINIC, INC.**

2362 TWO NOTCH ROAD  
COLUMBIA, SOUTH CAROLINA 29204

(803) 799-7007

**BRUCE D. FILLER, M.Ed. R.P.T.**

**ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION:**

This is to authorize The Columbia Rehabilitation Clinic, Inc. to make available to my insurance company and/or my attorney (s) any and all medical records or information that may aid in processing properly my claim and to represent me in a claim for injuries sustained as result of an accident or illness. I further request that copies of my bills be sent to my attorney (s) and hereby authorize my attorney (s) or insurance company to pay directly to The Columbia Rehabilitation Clinic all bills in full.

I also fully understand that if bills are not paid at all, or paid only partly by the insurance company and/or attorney (s), that I am fully and personally responsible for all my medical expenses as presented by The Columbia Rehabilitation Clinic. It was carefully explained to me and I fully understand that The Columbia Rehabilitation Clinic's charges for examination, treatment, etc. are to be paid fully by me regardless of the outcome of my suit or negotiations.

I further promise to pay the full amount of the bill submitted by The Columbia Rehabilitation Clinic, Inc. should the insurance company refuse to pay the claim or pay the bill directly to me.

I have carefully read and understand the above statements and confirm this with my signature below.

\_\_\_\_\_  
(Patient or Guardian)

\_\_\_\_\_  
(Witness)

\_\_\_\_\_  
(Date)