ALL THERAPY™
Physical Therapy & Wellness

Movement is freedom™

101 N. Broad Street
Middletown, DE 19709
(302) 376-5578 (b) * (302) 376-5580 (f)
www.ALLTherapy.net

AUTHORIZATION AND RELEASE FORM

I authorize the release of any information including the diagnosis and the records of any treatment examination rendered to my child or me during the period of such care to third party payers and /or health practitioners.

I authorize and request my insurance company to pay directly to the Physical Therapist insurance otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____ _____
Signature of patient or parent of minor Date

MEDICARE PATIENTS ONLY:

Name of Beneficiary _____ Medicare # _____

I request that payment of authorized MEDICARE benefits be made on my behalf to **ALL Therapy, G02248** for services rendered to me by the provider. I authorize any holder of medical information about me, and any information needed to determine these benefits, or the benefits payable for related services, to be released to Medicare services.

_____ _____
Patient's Signature Date

_____ _____
Provider's Signature Date