ALL THERAPY
Physical Therapy & Wellness

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

INSURANCE FILING AUTHORIZATION FORM

I understand that your signature on this form gives ALL Therapy the authorization to release any medical or other information necessary to process my health insurance claims for the treatment I receive at their facility. I also authorize direct payment of medical benefits to ALL Therapy for services rendered.

Patient Name: ____

Patient or Authorized Persons Signature: ____

Authorized Persons relationship to Patient: ____

Date: _________________________ (This authorization is good for One (1) year from date of service)

Office Staff Signature: ____