

September 2013

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: _____