

PTC Physical Therapy Patient Authorization Form

I request that payment of insurance benefits for services rendered to me be paid directly to PTC Physical Therapy. I authorize Medicare to send claims to my secondary insurance for crossover benefit payments. I authorize PTC Physical Therapy to release medical information to my insurance carrier to determine benefits payable. I understand that I may revoke this authorization at any time with a renewed and dated signature.

My insurance is:

Primary : _____

Secondary: _____

Date: _____

Signature: _____

I wish to revoke the above release for payment/release of medical information.

Date: _____

Signature: _____