OnetoOne PHYSICAL THERAPY
The doctors' choice for personalized care

AUTHORIZATION FORM
(Please Print)

MEDICARE LIFETIME SIGNATURE AUTHORIZATION

Medicare patient certification – patient certification authorization to release information and payment request. I certify the information given by me in applying for payment under Title XVIII and/or Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carriers, any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physical therapy services to One to One Physical Therapy. I understand that I am responsible for my health insurance deductible and coinsurance.

X _____

SIGNATURE of Patient's/Beneficiary's Name — Date

X _____

PRINT Patient's/Beneficiary's Name

MEDIGAP SIGNATURE AUTHORIZATION

I request that payment of authorized Medigap benefits be made on my behalf to One to One Physical Therapy for services furnished me by the therapists of One to One Physical Therapy. I authorize the holder of information about me to release to _____(insurance company) any information needed to determine these benefits or the benefits payable for related services. In understand that I am responsible for payment (if applicable) of any balance not paid by my insurance company.

X _____

SIGNATURE of Patient's/Beneficiary's Name — Date / HIC (Medicare) Number

X _____

PRINT Patient's/Beneficiary's Name — Medigap Policy Number

COMMERCIAL/WORKER'S COMPENSATION/NO FAULT LIFETIME AUTHORIZATION

I authorize the release of any medical information necessary to process my insurance claim(s). I request that the payment authorized be made on my behalf. I assign the benefits payable for physical therapy services to One to One Physical Therapy. I request that this authorization apply to all insurance claims, present and future. I understand that I am responsible for payment (if applicable) of any balance not paid by insurance company.

X _____

SIGNATURE of Patient's/Beneficiary's Name — Date

X _____

PRINT Patient's/Beneficiary's Name