S.M.A.R.T. Physical Therapy

PATIENT AUTHORIZATION

I, _____, hereby authorize Smart Physical Therapy, LLC to apply for benefits on my behalf for covered services rendered by SMART Physical Therapy, and request payment from my insurance carrier be made directly to SMART Physical Therapy.

I certify that the information I have reported with regard to my insurance coverage is correct. I further authorize the release of any necessary information, including medical information, to my insurance carrier (or in the case of Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration) in order to determine benefits to which I may be entitled.

This authorization may be revoked, by either me or my insurance carrier, at any time in writing. I permit a copy of this authorization to be used in place of the original.

_____ _____

Signature of Patient or Legal Guardian Date

_____

Patient's Name (please print)

_____

Relationship to Patient (if applicable)

SMART Physical Therapy, 11 Pleasant St., New London NH, 03257 Phone: 603-526-7627 Fax 603-676-7967 email: tim@smartptnh.com