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mignaccapt.com

Authorization Signature Form

I request that payment of insurance benefits for services rendered to me be paid directly to Mignacca Physical Therapy, Ltd.

I authorize my insurance(s) to send claims to my supplemental insurance(s) for crossover benefit payments.

I authorize Mignacca Physical Therapy, Ltd. to release all medical information to my insurance carrier(s) 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:		
Patient Name			_
Patient or Guardiar	n Signature		_
Date			-
I wish to revoke the	e above release for payme	ents/release of medical infor	mation.
Patient Signature		 Date	