

NEW PATIENT FORMS
PATIENT AUTHORIZATION

2440 M Street, NW Suite 322
Washington, DC 20037
Tel: 202 659 CORE(2673)
Fax: 202 659 0797
www.coreptdc.com

I, _____, hereby authorize C.O.R.E. Physical Therapy, PLLC (C.O.R.E.) to apply for benefits on my behalf for covered services rendered by C.O.R.E., and request payment from my insurance carrier be made directly to C.O.R.E..

I certify that the information I have reported with regard to my insurance coverage is correct and 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.

The 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 (if Legal Guardian)

Relationship to Patient (if applicable)