HUDSON VALLEY ORTHOPAEDIC & SPORTS PHYSICAL THERAPY
1222 Hopewell Avenue ~ Fishkill, NY 12524-1335 ~ 845-896-5380

If we will be filing insurance forms for you, please read, date and sign this form. Return it to the front desk when it is completed. Thank you.

PATIENT NAME (please print): ____
first middle last

Statement supporting your "Signature On File" for Insurance payment.

"I hereby authorize Hudson Valley Orthopaedic & Sports Physical Therapy to file insurance claims on my behalf and to furnish any and all records pertaining to medical history, services rendered or treatment given to me or my dependent for purposes of review, investigation or evaluation of my insurance claims. If my coverage is under a group contract held by my employer, an association, trust fund, union or similar entity, this authorization also permits disclosure to them for purposes of utilization review of financial audit. If my insurance policy allows, I hereby "assign" or "authorize" direct payment to Hudson Valley Orthopaedic & Sports Physical Therapy toward any physical therapy services performed. This authorization shall become effective immediately and shall be valid until rescinded in writing or replaced by one of a later date. A photostatic copy of this authorization shall be considered as effective and valid as the original."

DATE: ____________________________

PATIENT SIGNATURE: ____

PARENT OF LEGAL GUARDIAN NAME (please print):

____
first middle last

RELATIONSHIP TO PATIENT: ____

PARENT OR LEGAL GUARDIAN SIGNATURE: _______________________________