

The following paragraph is for the MEDICARE patients only.

I certify that the information given by me in applying for payment under title XVII of the Social Security Act is correct, I authorize any holder of medical or other information about me to release the Health Care Financing Administration or its intermediaries or carriers any information needed for this or related Medicare claim. I assign the benefits payable to covered Medicare services to the physician or organization furnishing the services or authorize such physician to submit a claim to Medicare for payment to me. I request the payment under the medical insurance program be made to either me or,

Doctor's Name

Patient's Name

Signature of Patient

Medicare No.

Date Signed

Dr. Theodore Kress, OD
Dr. Christopher Stansbury, OD

Date

Staff Tech.

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