PATIENT SIGNATURE ON FILE

1.MEDICARE

ENTITLEE'S NAME_____

MEDICARE NUMBER_____

I request that my payment of authorized benefits be made either to me or on my behalf to the doctor for services provided. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needs to determine these benefits or the benefits payable for related services.

Privacy Practices is made available upon request.

This authorization is in effect until I choose to revoke it.

PATIENT SIGNATURE_____DATE_____

2.OTHER INSURANCE

I hereby authorize payment of my medical insurance benefits to **Dr.Berry/ Dr Ducharme/ Dr Ness**.
I understand I am financially responsible for any charges whether or not paid by said insurance.
If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to **Dr.Berry/ Dr Ducharme/ Dr Ness**. I authorize **Dr.Berry/ Dr Ducharme/ Dr Ness** to release any information required to process any and all claims for reimbursement on my behalf. A copy of this authorization may be used in place of the original.

Privacy Practices is made available upon request.

This authorization is in effect until I choose to revoke it.

PATIENT SIGNATURE_____ DATE_____