**SIGNATURE PAGE**

**ONE-TIME MEDICARE AUTHORIZATION STATEMENT**

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and Bryan C Davis MD PA and/or Bryan K Dennett MD PA, which accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment.

**MEDIGAP AUTHORIZATION**

I authorize any holder of medical or other information about me to release any information needed for this or a related Medigap claim and future claims. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and Bryan C Davis MD PA and/or Bryan K Dennett MD PA, which accepts assignment.

**ASSIGNMENT OF BENEFITS & AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

I request that payment of authorized benefits Medicare, Medicaid, and/or Insurance Carrier listed, be made to me or on my behalf to the provider listed on this form, for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to release it to the Division of Family Services, the Health Care Financing Administration, listed insurer(s), and/or agents of these companies, and/or the listed responsible person(s), any information needed to determine these benefits or the benefits for other related services.

I request payment of authorized Medical benefits be made to Bryan C Davis MD PA and/or Bryan K Dennett MD PA, and also authorize any holder of medical information about me to release to the above named Medigap insurer any information needed to determine benefits payable for services from this provider.

I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE NOT COVERED BY MY INSURANCE CARRIER(S).

Patient/Guarantor Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

A copy of this signature is as valid as the original.