MEDICARE ACCEPTED AUTHORIZATION FOR SIGNATURE ON FILE

Name of Patient______________________________

I request that payment of authorized Medicare benefits be made to Pitman Creek Physical Therapy, P. C. for any services furnished to me. I authorize Pitman Creek Physical Therapy P. C., or any holder of medical information about me, to release to the Center for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature of Patient________________________________

Date______________________________