SOSAR PHYSICAL THERAPY *649 S. GARFIELD AVE.*
570.874.2125 *FRACKVILLE, PA 17931*

MEDICARE PATIENTS SIGNATURE REQUIRED

SIGNATURE ON FILE

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my therapist to submit claims for benefits or for services rendered without obtaining my signature on each and every claim form to be submitted for myself and/or dependents, and that I will be bound by this signature as through the undersigned had personally signed the particular claim.

MEDICARE POLICY

I understand that I am responsible for any **deductible** amount that has not been met for the year and for the 20% **co-insurance amount** if I do not have additional insurance. I also understand that I am financially responsible for any treatments that exceed the Medicare $1590 cap. I have received a copy of the Medicare Billing Policy and Fraud Notice and fully understand the billing policy.

MEDIGAP AUTHORIZATION

I request payment of authorized Medigap benefits be made on my behalf to SOSAR PHYSICAL THERAPY for any services furnished to me by that provider. I hereby authorize the physical therapist to release any information needed to determine these benefits or the benefits payable for related services.

SIGNATURE DATE

2003