NeuroScience Associates

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MEDICARE PAYMENT AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr Henbest, Dr. Johans, Dr. Andersen, Dr. Montalbano, Dr. Hajjar, Dr Little, or Dr. Manning. I also further authorize and direct any holder of medical information about me to release such information to the Centers of Medicare and Medicaid Services, formerly the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. This authorization shall remain in full force and effect until revoked in writing by myself. A copy of this authorization shall be as valid as the original.

Signature: ____

Date: ______________________________