Board Certified Otolaryngology
Head & Neck Surgery

NAME:____ **Soc. Sec. #**___________________________

Date of Birth:_____________________ **Sex:**______

Medicare Patients Only

I request that payment of authorized Medicare benefits be made on my behalf to Vero ENT Associates for any services rendered to me. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information needed to determine if these benefits are payable for related services. The Medicare providers Dr. Kathleen Baggett, Dr. Alex Yoon, Dr. Jeffrey Livingston, Dr. Alfred Filosa and Dr. Alexis Riley agree to accept the charge determination of Medicare as the full charge and the patient is responsible only for the deductible, co-insurance and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Signed:____ **Date:**____________________________