# Shapiro Eye Care, P.A.

## MEDICARE PATIENTS

Please read and sign the following statement.

I request payment of authorized Medicare benefits to be made either to me or on my behalf to Shapiro Eye Care for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

_____ _____

DATE SIGNATURE