Kevin J. Klos, M.D.

MDC
the MOVEMENT DISORDER CLINIC of Oklahoma

Electromyogram (EMG)
Botox Services
Tremor Analysis
Deep Brain Stimulation
Parkinson's Disease Center

Patient Authorization Form

MEDICARE

Name of Beneficiary _____

HI Claim Number or Medicare Number_____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Klos 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. I hereby authorize Medicare to furnish to the above named doctor any information regarding my Medicare claims under Title XVIII of the Social Security Act.

COMMERCIAL INSURANCE

I, _____, hereby authorize release of information necessary to file a claim with my insurance company and ASSIGN BENEFITS OTHERWISE PAYABLE TO ME TO THE DOCTOR OR GROUP INDICATED ON THE CLAIM. I understand I am financially responsible for any balance not covered by my insurance carrier. A copy of this signature is as valid as the original.

_____ _____

Signature Date

The Movement Disorder Clinic of Oklahoma
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