OSER & TAUBER, M.D., P.A.

10301 GEORGIA AVENUE, SUITE 304
SILVER SPRING, MARYLAND 20902
Telephone (301) 681-7200

PATIENT'S AUTHORIZATION

I hereby authorize Oser & Tauber, M.D., P.A. to apply for benefits on my behalf for covered services rendered. I request that payment from Medicare and/or other insurance carrier be made directly to Oser & Tauber, M.D., P.A.

I certify that the information I have reported is correct. I authorize the disclosure of any necessary information, including protected health information, for treatment, payment, and healthcare operations. Such information may be required by my insurance carrier (or in the case of Medicare Part B benefits, by the Social Security Administrator and the Centers for Medicare and Medicaid Services - CMS).

I assume financial responsibility for and agree to make payment in full to Oser & Tauber, M.D., P.A. for all charges for services rendered not otherwise authorized or paid by my insurance carrier.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me or the above-mentioned carrier at any time in writing.

PATIENT/RESPONSIBLE PARTY SIGNATURE	INSURANCE IDENTIFICATION NUMBER	TODAY'S DATE

PATIENT NAME First Middle Last				DATE OF BIRTH		INSURED'S DOB (If different)
HOME ADDRESS APT. NO.		CITY		STATE	ZIP CODE	HOME PHONE
OCCUPATION	SOCIAL SECURITY NO.	MARITAL STATUS [ ] S [ ] M [ ] D [ ] W		SEX [ ] M [ ] F		CELL PHONE
EMPLOYER	ADDRESS					WORK PHONE
SPOUSE'S NAME (OR PARENT)		SPOUSE'S EMPLOYER (OR PARENT)				SPOUSE'S WORK PHONE (OR PARENT)
IN CASE OF EMERGENCY CONTACT	RELATIONSHIP		WORK PHONE			HOME PHONE
REFERRED BY	ANY DRUG ALLERGIES, IF SO LIST					

BILLING INFORMATION

FINANCIALLY RESPONSIBLE PERSON [ ] Patient [ ] Spouse [ ] Parent [ ] Other ____________	NAME (if different from patient)	HOME PHONE
FINANCIALLY RESPONSIBLE PERSON'S ADDRESS (If different from Patient)		
FINANCIALLY RESPONSIBLE PERSON'S EMPLOYER	EMPLOYER'S ADDRESS	WORK PHONE

PATIENT #________________________