

**Katonah Physical Therapy, P.C.  
190 Goldens Bridge Rd.  
Katonah, NY 10536**

**Medicare Claim Authorization**

**I request that payment of authorized Medicare benefits be made to Katonah Physical Therapy, P.C., for services rendered to me by the provider. I understand that Medicare will pay 80% of covered charges and that I am responsible for ensuring payment of the remaining 20%.**

**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**

**Signature: \_\_\_\_\_ Date: \_\_\_\_\_**

**Name (print): \_\_\_\_\_**