# Susan P. Epner, M.D.

Adult Neurology Board Certified

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Sign if Applicable

## MEDICARE LIFETIME SIGNATURE ON FILE

I request that payment of authorized Medicare benefits be made to Susan P. Epner, M.D. for any services furnished to me by this 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 benefits payable for related services.

Signature: ______________________________________________________ Date: _________________

## MEDICAID AUTHORIZATION

I authorize payment of medical benefits to Susan P. Epner, M.D. for services provided to me.

Signature: ______________________________________________________ Date: _________________

## SIMPLE AGREEMENT FORM FOR DIRECT ASSIGNMENT OF INSURANCE BENEFITS

Patient authorizes Susan P. Epner, M.D. to deposit checks received on Patient's account when made out to the Patient.

Signature: ______________________________________________________ Date: _________________