Diane Aukland, L.C.S.W.
Licensed Clinical Social Worker

NAME OF BENEFICIARY _____ HIC NUMBER _____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Diane Aukland, L.C.S.W. for any services furnished me by that supplier. 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 payable to the related services.

I understand my signature requests that payment be made and to authorize release of medical information necessary to pay the claim. If other health insurance coverage is indicated in Item 9 of the HCFA-1500 claim form or on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the supplier agrees to accept the charge determination of the Medicare carrier as the full charge. The patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

SIGNATURE OF BENEFICIARY _____ DATE _____

WITNESS _____ DATE _____

42525 Rancho Mirage Lane, Rancho Mirage, Ca 92270
Appointment Desk: 760-898-2169 Fax: 760-832-8080 Confidential voice mail: 760-668-7665