

**ADDENDUM TO PATIENT REGISTRATION FORM:**  
*For MEDICARE Patients only*

NAME OF BENEFICIARY \_\_\_\_\_ MEDICARE #: \_\_\_\_\_

SECONDARY INSURANCE \_\_\_\_\_

I request that payment of authorized MEDICARE benefits be made to me or on my behalf to:

CAROL STILLMAN, MSPT

PROVIDER # Q22011

For services rendered to me by the provider, I authorize any holder of medical information about release to the Health Care Financing Administration and its agents any information needed to do these benefits or the benefits payable for related services.

\_\_\_\_\_  
Patient's signature

\_\_\_\_\_  
Provider's signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date