Fratellone Medical Associates, LLP

47 West 57th Street – 5th Floor East
New York, New York 10019

Signature on File Agreement

EMPIRE MEDICARE SERVICES

For Medicare Patients Only

I, ______________________________ request that payment of authorized benefits be made on my behalf to Patrick Fratellone, MD – Fratellone Medical Associates, LLP for services furnished to me by the provider. I authorize any hold of medical information about me to release to **Empire Medicare** any information needed to determine these benefits payable for related services

______________________________	______________________________
Patient Signature	Date
______________________________	______________________________
Witnessed by FMA, LLP	Position/Title