Glenn Marron, PhD, PLLC
280 Madison Ave, Ste 805
New York, NY 10016
Phone: 917 608-8482

Signature on File Agreement

Patient's Name: _____

Insurance ID _____

I request that payment of authorized benefits be made on my behalf to Glenn Marron, PhD, PLLC for services furnished to me by the provider.
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.

Patient Signature: Date:

_____ _____