

Lynn H. Deutsch, D.O.

Geriatric Psychiatry | 6205 Executive Blvd | Rockville, MD 20852

REGISTRATION FORM

Patient Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Medicare Number: (includes letter at end) _____

Secondary Insurance: _____

Dr. Deutsch is a Medicare Provider and accepts assignment. The office will bill Medicare. I agree that Medicare and Secondary Insurance payments may be sent directly to Dr. Deutsch.

Signature (patient or Power of Attorney): _____

Date _____