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1223-B MONTAUK HIGHWAY
OAKDALE, NEW YORK 11769

AUTHORIZATION FOR USE OF SIGNATURE ON FILE FOR CLAIM AUTHORIZATION AND ACKNOWLEDGEMENT OF NON COVERED SERVICES

Patient Name _____

I, _____authorize Dr. Gary S. Kasten to mark the section "Enrollee's or Authorized Person's Signature, with the Notation "SIGNATURE ON FILE".

This Section Authorizes

1. The release of any medical information necessary to process the claim.
2. Payment of medical benefits to the undersigned physician or supplier or services described below.

In addition, I acknowledge that there may be services performed that are not covered by my insurance carrier and that I will be responsible for payment of these services. Some examples are as follows: PESSARY RINGS, DIAPHRAGM, IUD, CONTRACEPTION, and WELL WOMEN VISITS. I understand that it is my responsibility when scheduling an appointment to know the limits of my insurance coverage.

This authorization will remain in force until terminated in writing by the enrollee.

Name (printed) _____