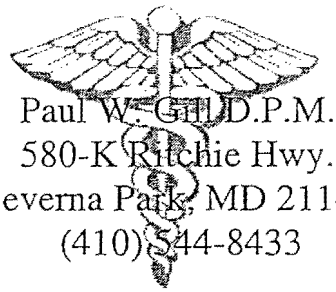

Paul W. Gill D.P.M.
580-K Ritchie Hwy.
Severna Park, MD 21146
(410) 544-8433

I, _____ hereby authorize Paul W. Gill D.P.M. to apply for benefits on my behalf for covered services rendered. I request payment from my primary insurance carrier _____ (Or in case of Medicare Part B. benefits, to myself or the party who accepts assignment), and/or my secondary/supplemental insurance carrier _____ (if applicable).

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim, to the above named billing agent. I permit a copy of this authorization to be used in place of the original. Either the above-named carrier or I may revoke this authorization at any time in writing.

I authorize any holder of medical information about me to release to the above named insurer any information needed to determine these benefits payable for related services.

I request that payment of authorized Medigap benefits be made either to me or on my behalf to Paul W. Gill D.P.M. for any services furnished by me that physician/group

_____ _____

(Signature of Subscriber or beneficiary/patient) (Date)

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so choose) and understood the Notice.

Copies of Notice of Privacy Practices are located on the counter at the reception desk and are always available.

_____ _____

Patient Name (Please Print) Date

_____

Parent or Authorized Representative (if applicable)

_____

Signature