FORM 2

PATIENT'S INSURANCE AUTHORIZATION

I hereby authorize the processing of the Medical Insurance Either by electronic or manual method by the listed Provider below. My signature authorizes payment of all major medical and/or surgical benefits to which I am entitled from the listed Insurer below to pay the listed Provider Assignee. I further authorize the Assignee to release all medical and/or insurance claim information necessary to secure the payment(s). I recognize my financial obligation of any co-insurance or deductible and non-covered services that may be required. This agreement will remain in effect until revoked by me in writing. A copy of this document is considered as valid as an original.

Patient's Name	Patient's Signature

Provider's Name
Andrew Wilantewicz

Address
282 New Hackensack Road

City	State	Zip Code
Wappingers Falls	N.Y.	12590

Patient's Insurance Company

Policy Number	Group Policy I.D.

Date