Please print name:______________________________________________

## SIGNATURE PAGE

**AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:** I hereby authorize payment directly to Dr. Kim Keller for the surgical and/or medical benefits, if any, which are otherwise paid to me for his services as described, realizing that I am responsible to pay non-covered services.

Signature (Patient or Authorized Person)______________________________Date__________

**AUTHORIZATION TO RELEASE INFORMATION**: I HEREBY AUTHORIZE Dr. Kim Keller to release any information acquired in the course of my treatment which is necessary to process insurance claims.

Signature (Patient or Authorized Person)______________________________Date__________

**NOTICE OF PRIVACY PRACTICES**: I have been provided the opportunity to review the Notice of Privacy Practices for Kim D. Keller, M.D., P.A.

Signature (Patient or Authorized Person)______________________________Date__________