AUTHORIZATION TO PAY PHYSICIAN

I hereby authorize the _____ Insurance Company to pay by check made out and directly mailed to:

Hawthorne Pain and Spine Center
Dr. Peter Berger, Michael Lee Acupuncturist and Joseph Pantiliano Acupuncturist
219 Lafayette Ave.
Hawthorne, NJ 07506

The medical and surgical expense benefits allowable and otherwise payable to me under my current insurance policy, as payment toward the total charges for Professional Services rendered. This payment will not exceed my indebtedness to the above mentioned assignee, and I agree to pay, in current manner, any balance of said Professional Services charges over and above this insurance payment.

If my current policy prohibits direct payments to the doctor, then I hereby authorize you to make the check to me and mail it as follows:

Hawthorne Pain and Spine Center
Dr. Peter Berger, Michael Lee Acupuncturist and Joseph Pantiliano Acupuncturist
219 Lafayette Ave.
Hawthorne, NJ 07506

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to any case to my insurance company, adjuster, or attorney involved in this case.

Date: _____ 20 _____

_____ _____
Signature of Policyholder Signature of Witness

_____
Signature of Parent/Guardian