AUTHORIZATION TO PAY PHYSICIAN

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

DR. ROBERT'S MEDICAL CENTER
9349 Oak Street
Bellflower, CA 90706
(562) 920-6070
FAX: (562) 920-6074

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 above mentioned assignee and I have agreed to pay, in a current manner, any balance of said Professional Service charges over and above this insurance payment.

Date_____ _____

Signature

_____

Full Name

_____

(Street Address)

_____

(City) (State) (Zip Code)