INSURANCE PAYMENT AUTHORIZATION FORM

PATIENT NAME:_____

SOC. SEC. #:_____ EMPLOYER NAME:_____

POLICY #:_____ GROUP #:_____

I HEREBY INSTRUCT AND DIRECT THAT MY CURRENT INSURANCE COMPANY, _____, PAY BY CHECK, MADE OUT AND MAILED TO:

PAUL W. MACELLARI, PH.D., P.C.
135 RED COACH DRIVE
MISHAWAKA, INDIANA 46545

OR

IF MY CURRENT POLICY PROHIBITS DIRECT PAYMENT TO DOCTOR, THEN I HEREBY ALSO INSTRUCT AND DIRECT YOU TO MAKE OUT THE CHECK TO ME AND MAIL IT AS FOLLOWS:

C/O PAUL W. MACELLARI, PH.D., P.C.
135 RED COACH DRIVE
MISHAWAKA, IN 46545

THE PROFFESSIONAL OR MEDICAL EXPENSE BENEFITS ALLOWABLE, AND OTHERWISE PAYABLE TO ME UNDER MY CURRENT INSURANCE POLICY AS RENDERED. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. THIS PAYMENT WILL NOT EXCEED MY INDEBTEDNESS TO THE 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.

A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AS THE ORIGINAL.

I ALSO AUTHORIZE THE RELEASE OF ANY INFORMATION PERTINENT TO MY CASE TO ANY INSURANCE COMPANY, ADJUSTER, OR ATTORNEY INVOLVED IN THIS CASE.

PATIENT AUTHORIZES THE DOCTOR TO COMPLAIN TO THE INSURANCE COMMISSIONER FOR ANY REASON.

DATED AT DR. MACELLARI'S OFFICE, THIS _____ DAY OF _____ 20____

_____ _____
SIGNATURE OF POLICYHOLDER WITNESS

_____
SIGNATURE OF CLAIMANT (IF OTHER THAN POLICY HOLDER