PATIENT: ______________________________

SOCIAL SECURITY #: ______________________________

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize, instruct, and direct my insurance company (or companies) to pay directly to the doctor the amount(s) due on my claim for services rendered to me or my dependent. Such payment shall be made payable and mailed to my doctor as follows:

BRIAN L. FLYER, M.D.
1125 S. BEVERLY DRIVE, SUITE #700
LOS ANGELES, CA 90035

If my current policy prohibits direct payment to the doctor, then I hereby also instruct and direct you to make the check out to me and mail it as follows:

BRIAN L. FLYER, M.D.
1125 S. BEVERLY DRIVE, SUITE #700
LOS ANGELES, CA 90035

I further agree that should the amount be insufficient to cover the entire medical and surgical expense, I will be responsible for payment of the difference; and if the nature of the disability be such that it is not covered by the policy, I will be responsible to the doctor for payment of the entire bill.

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

I understand that as a courtesy to me, the patient, the doctor will bill my insurance. However, the doctor cannot and will not be resp,onsibile for collecting payments or negotiating settlements on disputed claims. It is the policy of the doctor to allow 60 (sixty) days for insurance to pay claims, at which time payment is expected by me, the patient. **Patients are expected to pay toward their deductible and co-payments at the time of the visit.**

COLLECTION & ATTORNEY FEES

Should the doctor need to employ an attorney or collection agency to enforce payment for treatment rendered, the patient agrees to pay the reasonable attorney and/or collection agency fees incurred for such enforcement.

RELEASE OF RECORDS

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

SIGNATURES

I UNDERSTAND AND AGREE THAT REGARDLESS OF MY INSURANCE STATUS, I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE ON MY ACCOUNT FOR ANY PROFESSIONAL SERVICES RENDERED. I certify that the information that I have provided is true and correct to the best of my knowledge, and I will notify you of any changes in my health status, address; or insurance information. I have read and agree to the above.

______________________ PATIENT'S SIGNATURE ________ DATE

______________________ WITNESS ________ DATE

______________________ INSURED'S SIGNATURE ________ DATE