Patient Name: Date:

Email:

Employer:

Insurance Company:

Insurance Identification Number:

I hereby instruct and direct the above named insurance company to pay by check made payable to and mail to:

Advanced Oral and Maxillofacial Surgery/Dr. Robert DeFalco
270 Spring Valley Road
Paramus, NJ 07652

OR

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

Name of Patient:

C/O Advanced Oral and Maxillofacial Surgery/Dr. Robert DeFalco
270 Spring Valley Road
Paramus, NJ 07652

for the professional/ medical/ or dental expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services 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 timely manner, any balance of said professional service charges over and above this insurance payment.

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 my case to any insurance company, adjustor, or attorney involved in this case.

I authorize Dr. Robert DeFalco to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Signature of Policy Holder: Witness:

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