Miami Surgery

20200 W. Dixie Hwy, Suite G03
Aventura, FL 33180

I HEREBY INSTRUCT AND DIRECT _____ INSURANCE COMPANY TO PAY CHECK OUT AND MAILED TO **MIAMI SURGERY LLC.** IF MY CURRENT POLICY PROHIBITS DIRECT PAYMENTS TO THE DOCTOR, I HEREBY INSTRUCT AND DIRECT YOU TO MAKE OUT THE CHECK TO ME AS FOLLOWS: 20200 W DIXIE HWY. SUITE G05. AVENTURA, FL 33180

I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO MY INSURANCE CARRIER ANY INFORMATION NEEDED FOR THIS OR ANY RELATED CLAIM.

I HEREBY AUTHORIZE, REQUEST AND ASSIGN PAYMENT DIRECTLY TO JOSHUA LAMPERT, M.D.,P.A. FOR BILLS RENDERED. COVERING MEDICAL SERVICES, AND ANY PAST AND FUTURE TREATMENTS. IF RELATED TO THE INCIDENT OR CONDITION GIVING RISE TO THESE SERVICES, BY ALL INSURANCE CARRIERS WITH WHOM I HAVE COVERAGE OR FROM WHOM BENEFITS ARE, OR MAY BECOME PAYABLE TO ME INCLUDING SETTLEMENTS OR JUDGMENTS FOLLOWING FROM THE INCIDENT FOR WHICH I AM RECEIVING TREATMENT. THIS AUTHORIZATION SHALL INCLUDE ALL BENEFITS SPECIFIED AND/OR MASTER MEDICAL BENEFITS OTHERWISE PAYABLE TO ME.

I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL.

I AUTHORIZE **MIAMI SURGERY LLC** . TO INITIATE A COMPLAINT TO THE INSURANCE COMMISSIONER FOR ANY REASON ON MY BEHALF.

_____ _____

Signature of Policy Holder Date