SOUTH FLORIDA INJURY CENTERS, Inc.
5715 N University Dr.
Tamarac, FL 33321

AUTHORIZATION TO PAY DOCTOR

I hereby authorize ________________________________(insurance company) to pay by check made out and mailed to:

South Florida Injury Centers, Inc.
5715 N. University Dr.
Tamarac, FL 33321

The 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 shall not exceed my indebtedness to above mentioned assignee and I have agreed to pay, in current manner, any balance of said professional service charged over and above this insurance payment.

____
Date

____
Patient's Printed Name

____
Patient's Signature