

MADHU BERMAN, MD

29000 S. Western Avenue, Suite 200 *Rancho Palos Verdes, CA 90275

1200 Rosecrans Avenue, Suite 202 *Manhattan Beach, CA 90266

INSURANCE INFORMATION

PRIMARY INSURANCE _____
NAME OF INSURED _____
DATE OF BIRTH _____ **RELATIONSHIP TO PT** _____
SOC SEC #: _____ **I.D. #** (if different from SSN) _____

SECONDARY INSURANCE _____
NAME OF INSURED _____
DATE OF BIRTH _____ **RELATIONSHIP TO PT** _____
SOC SEC #: _____ **I D#** (if different from SSN) _____

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR

I hereby instruct and direct that _____ Insurance Company
to pay for medical services by check made out and mailed to:

MADHU BERMAN, MD
29000 S. WESTERN AVENUE, SUITE 200
RANCHO PALOS VERDES, CA 90275

If the current insurance policy prohibits direct payment to the doctor, then I will make payment directly to:
MADHU BERMAN, MD

The check will be for the professional or medical 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 UNDERT 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 that are part of my deductible and co-payment.

If my insurance company pays the check to me for the medical services provided by Madhu Berman, MD I will send that check or write a check for an equal amount to MADHU BERMAN, MD.

I AM AWARE THAT MADHU BERMAN, MD DOES NOT TAKE ANY HMO INSURANCE. IF MY INSURANCE COMPANY NEEDS TO GIVE AUTHORIZATION/REFERRAL FROM MY PRIMARY CARE PHYSICIAN, IT IS MY DUTY TO GET THE NECESSARY REFERRAL AND AUTHORIZATION DOCUMENT BEFORE COMING TO SEE DR. MADHU BERMAN. OTHERWISE, I AM RESPONSIBLE TO PAY FOR ALL SERVICES RENDERED.

A photocopy of this Agreement 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, adjuster, or attorney involved in this case.

Dated at city of Rancho Palos Verdes this _____ day of _____, 200__.

Signature of Policyholder

Witness

Signature of Claimant, if other than Policyholder