

## AUTHORIZATION TO PAY DOCTOR

I hereby authorize the \_\_\_\_\_ insurance company to send payment directly to

**Elizabeth A. Greenberg, D.C.  
89 Fifth Avenue Suite 604  
New York, N.Y. 10003**

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 named assignee and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

**patient signature** \_\_\_\_\_

**print name** \_\_\_\_\_

**email address** \_\_\_\_\_

**date** \_\_\_\_\_