TARZANA SURGERY CENTER
18425 BURBANK BLVD. SUITE 105
TARZANA, CA 91356
TEL (818) 654-0595 FAX (818) 654-0516

AUTHORIZATION TO PAY

Date: _______________

I hereby authorize ______________________________________ Insurance Company to pay by check made out and mailed directly to:

Tarzana Surgery Center
18425 Burbank Blvd. Suite 105
Tarzana, CA 91356
Tel (818) 654-0595 Fax (818) 654-0516

the medical and surgical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for Services Rendered by Tarzana Surgery Center. The payment will not exceed my indebtedness to above mentioned assignee and I have agreed to pay, in a current manner any balance of said service charges over and above this insurance payment.

____________________________ ________________________
Patient's Signature Date & Time

____________________________ ________________________
Name (Please Print) Address

____________________________ ________________________
Witness Signature Date & Time