



David Evdokimow, MD
PLASTIC & RECONSTRUCTIVE SURGERY

96 S. Finley Avenue
Basking Ridge, NJ 07920

Authorization & Assignment

I authorize & request _____ Insurance Company to pay directly to the above named medical provider, the amount due under the terms of the above-referenced policy as a result of medical care rendered by that medical provider and all medical staff associated with the provider’s office.

Date: _____ Parent/Legal Guardian: _____

I authorize David Evdokimow M.D. Plastic & Reconstructive Surgery to release any information deemed appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred.

In the event the insurance company obligated by contractual agreement to make payment to me or to you for charges made for your services refused to make such payment upon demand to you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name (s) of which is believed to be correctly set forth under pertinent date) and authorize you to compromise, settle or otherwise resolve said claims as you see fit.

In addition to the above, I hereby waive the statute of limitation on collections and or recovery in this state, New Jersey.

I further agree that this “Authorization” is irrevocable until all monies owed are paid in full.

Date: _____ Patient’s signature: _____

If you are a minor or if represented by another party please provide information below.

Personal Representative: _____

Personal signature: _____

Representative

