AUTHORIZATION TO PAY PHYSICIAN

I hereby authorize _____Insurance Company
To pay by check made out and mailed to:

City Dental P.C.
11 Broadway,Mezzanine level
New York, NY

The dental and surgical 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 will not exceed my indebt to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

Dated_____
Signed_____
Address_____