Notice to Insurance Carrier

Dr. Vizzone is not a participating provider.

The signature below is authorization to have the payments for services rendered by Jerald P. Vizzone, D.O. to be sent DIRECTLY to the office.

I hereby authorize and direct my insurance carrier to pay directly to Jerald P. Vizzone, D.O.,P.A. any benefits under my plan.

I am also aware that if I cash the checks and do not pay Dr. Vizzone that I will immediately be placed into collections. * The checks must be endorsed to Dr. Vizzone within two weeks of issue from carrier *

_____ _____

Patient Name **ID Number**

_____ _____

Patient Signature **Date**