



New York House Call Physicians®

YOUR DOCTOR IN THE FAMILY

ASSIGNMENT OF BENEFITS FORM

I hereby authorize the office of NATAN SCHLEIDER, MD doing business as DOCTOR IN THE FAMILY to submit medical claims on my behalf to my insurance plan.

I authorize and direct my insurance company to pay by check payable to DOCTOR IN THE FAMILY and mailed to:

DOCTOR IN THE FAMILY
NATAN SCHLEIDER MD
35 EAST 35TH STREET, STUIE 1H
NEW YORK, NY 10016

This payment is for the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment towards the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS UNDER THIS POLICY. This benefit will not exceed my indebtedness to the above-mentioned assignee.

A photocopy of this Assignment shall be considered as effective and valid as the original.

Patient Name: _____

Patient Date of Birth: _____

Patient or Guardian Signature: _____

Date: _____