

**MARK D. EPSTEIN, M.D., F.A.C.S.**

**No-fault**

Was an automobile involved? \_\_\_\_\_ Date of injury: \_\_\_\_\_

Are you still working? \_\_\_\_\_ If no, last date worked: \_\_\_\_\_

No fault carrier: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone #: \_\_\_\_\_

Policyholder's name: \_\_\_\_\_

Claim #: \_\_\_\_\_

Policy #: \_\_\_\_\_

I, \_\_\_\_\_ hereby authorize payment of No-fault benefits directly to Mark D. Epstein, M.D. In the event that I fail to file a claim for No-fault benefits for this illness or condition, or it is determined by the No-fault carrier that the illness or condition is not a result of a compensable No-fault case, I hereby agree to pay Mark D. Epstein, M.D. his usual and customary fees for all services rendered.

I HEREBY AUTHORIZE MARK D. EPSTEIN, M.D. TO RELEASE INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT TO BE RELEASED TO MY NO-FAULT CARRIER AND/OR MY ATTORNEY.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_