Kevin Kessler, M.D.
Diplomate American Board of
Orthopaedic Surgery
Board Certified
Naveed Shafi, M.D.
Board Certified

Arthroscopic Shoulder,
Knee and Elbow Surgery
Orthopaedic Surgery

ASSIGNMENT OF BENEFITS FORM

Date: _____
Practice Name*: Kessler Sports Medicine Center*
Address: *4800 N Federal Highway, 3rd Floor*
City, State, Zip: *Fort Lauderdale, FL 33308*

Patient Name: _____
Employer: _____
Claim Group: _____
SS#/ID#: _____

I hereby instruct and direct_____Insurance Company to pay by check made out and mailed to:

Kevin J Kessler M.D.
4800 N Federal Highway, 3rd Floor
Fort Lauderdale, FL 33308

If my current policy prohibits direct payment to Doctor, I hereby also instruct and direct you to make out the check to me and mail it to the temporary address as follows:

Patient Name: _____

c/o Kevin J Kessler M.D.
4800 N Federal Highway, 3rd Floor
Fort Lauderdale, FL 33308

For the professional or healthcare expense benefits allowable and otherwise payable you I under my current insurance policy as payment toward the total charges for the professional services rendered**. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY**. This payment will not exceed my indebtedness 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.
A photocopy of this Assignment of benefits form shall be considered as effective and valid as the original.
I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize Doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

(Month)_____, (Day) _____, 20____

Signature of Policy Holder_____, Witness_____