



American Board of Orthopaedic Surgery, American Academy of Orthopaedic Surgeons  
Qualified Medical Evaluator  
7910 Frost Street, Suite 340  
San Diego, CA 92123  
Phone: (858) 277-2448 Fax: (858) 277-2492

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

ADDRESS: \_\_\_\_\_

CITY, STATE, ZIP CODE: \_\_\_\_\_

PHONE # (     ) \_\_\_\_\_ CELL # (     ) \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

WORK # (     ) \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

IN CASE OF EMERGENCY, NOTIFY : \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_ PHONE # (     ) \_\_\_\_\_

REFERRING PHYSICIAN: \_\_\_\_\_

INSURANCE PLAN : \_\_\_\_\_

MEDICAL GROUP (IF APPLICABLE) : \_\_\_\_\_

**PLEASE READ THE FOLLOWING AND SIGN BELOW**

I hereby authorize David G. Levinsohn, M.D., to furnish to my insurance company or to a designated attorney, all information which the insurance company or the attorney may request. I hereby assign to the above referenced physicians all monies to which I am entitled and/or surgical expense relative to the services rendered by either of them. It is understood that any money Received from the above mentioned insurance company, over and above my indebtedness will be refunded to me when my bill is paid in full. I understand I am financially responsible. WHETHER MY INSURANCE COMPANY PAY OR NOT for all costs incurred by me. I further agree that in the event of non-payment, I will bear the cost of collection and /or Court cost and reasonable legal fees should such court action be required. I agree that a photocopy of this authorization shall be as valid as the original.

\_\_\_\_\_  
PATIENT / RESPONSIBLE PARTY SIGNATURE

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
DATE