DR. JEFFREY D. GABER
& ASSOCIATES, PA

AGREEMENT AND AUTHORIZATION FOR DIRECT PAYMENT

I hereby authorize, assign, and direct my attorney to pay Dr. Jeffrey D. Gaber & Associates, P.A. such sums as may be owing to them for professional services rendered in the treatment of injuries sustained by me/my wife/my child as the case may be. If applicable, I authorize, assign, and direct my attorney to pay such sums from the proceeds of any settlement, judgment, or insurance policy, as may be necessary to adequately protect. Such payments will include all professional services rendered, and those rendered up to the time of settlement, including, but not limited to, the appearance as an expert witness in any forum, and such time as may be necessary to properly prepare and travel for such testimony. I further understand that my attorney(s) may request your appearance in a legal proceeding and acknowledge that such appearance is solely for my benefit and accept full responsibility for your fee associated with such appearance, such fees to be fixed at a rate of $800 per hour for Drs. Jeffrey D. Gaber and Jonathan Gitter and $850 hour for Dr. Douglas Shepard. I may also be charged for specialized reports prepared for, or at the request of my attorney, relating to any matter on which I have engaged a lawyer to assist me.

I authorize, assign, and direct any insurance carrier to pay directly to Dr. Jeffrey D. Gaber & Associates, P.A. such sums as may be owing to said for professional services as outlined above. I direct my attorney(s) to submit a copy of this AGREEMENT AND AUTHORIZATION FOR DIRECT PAYMENT to any and all insurance carriers which may be responsible for the payment of such sums, including an insurance carrier providing personal injury protection coverage to which I may be entitled.

I understand that any balance due on my account will be deducted from settlement or judgment proceeds even though Dr. Jeffrey D. Gaber & Associates, P.A. may now be, or at a future date may become, my primary caregiver in any health maintenance organization or managed care network.

I understand that I am directly and fully responsible to Dr. Jeffrey D. Gaber & Associates, P.A. for all bills submitted by Dr. Jeffrey D. Gaber & Associates, P.A., including attorney(s) fees of 25% of the balance due plus all costs resulting from efforts to collect any balance due, and that this agreement is made solely for their additional protection and in consideration of them awaiting payment. I further understand that my liability to pay Dr. Jeffrey D. Gaber & Associates. P.A. is not contingent on any settlement, judgment or verdict from which I may eventually recover such fee.

In the event I directly receive any proceeds of any insurance policy, including but not limited to proceeds from any claim under my personal injury protection coverage, or from any third-party payer, I agree to immediately make payment to Dr. Jeffrey D. Gaber & Associates, P.A. upon receipt of such monies.

A PHOTOCOPY OF THIS AGREEMENT SHALL BE BINDING AS THE ORIGINAL.

Date: _____ Signature: _____

Address: _____ Witness: _____

City: _____ State: _____ Zip: _____

Day Phone Number: _____ Cell Phone Number: _____

Attorney's Name: _____ Phone Number: _____