Assignment of Benefits Form

I _____ (Print Name) with insurance benefits through (Employer Name) _____ (Medicare, Medicaid, or Individual Plan) as well as my governing Health and Welfare Plan or any Social Security Act, including title XVIII of the Social Security Act, hereby appoint as my authorized representative in connection with my claim for all medical services requested and rendered, as well as all entitled benefits and protected rights under my Plan or Policy related to all services rendered or requested. I authorize the above named provider or any appointed business associate acting under a valid business associate agreement to make any request for appeal on my behalf, present or to elicit evidence; to obtain all appeal correspondence and findings; and to receive all notifications in connection with my appeal, wholly in my stead. I understand that personal medical information related to my appeal may be disclosed to an appointed business associated to act on my behalf as my appointed authorized representative. I authorize all entitled benefits under my Plan/Policy to be paid directly to the provider listed above for all services rendered. I understand that I am entitled to all benefits that my Health and Welfare or Social Security Plan is legally obligated to provide, including any legal claim to benefits under the governing Plan. I understand that my Plan Sponsor and Health Insurance Issuer are required to accept and honor this agreement for all services rendered, in full compliance of all governing state and federal laws. This authorization includes any and all rights permissible under my governing Health and Welfare Plan; applicable Social Security Act; Federal, City or State Government program; as well as state and federal law related to all services rendered. I understand this authorization also covers any and all other providers of service directly associated with services rendered and requested by the above provider, including but not limited to all other providers involved with surgical related services, including surgical assistants, anesthesiology services, diagnostic testing, labs, pathology, radiology, implants, tissues, or any other services rendered or requested by the provider above and entitled under my governing or Federal covered health Plan. I appoint and authorize the above provider and business associate appointed by the provider as my duly authorized and personal representative relating to all services rendered, rights of appeal, disclosure and remedies due me under law. I hereby certify that all insurance information provided is true and accurate and that I am responsible for keeping it updated. I understand that failure to provide accurate insurance information and coordination of benefit coverage at time of service or any failure to cooperate with the provider to the fullest extent to obtain full entitled reimbursement for all services rendered will result in my full financial responsibility of all services rendered. I hereby authorize the Provider listed above to submit claims, on my behalf, to the insurance company responsible for administering entitled benefits for all services rendered. I fully agree and understand that the submission of a claim does not absolve me of my responsibility to ensure the claim is paid in full and in full compliance of applicable state and federal laws. I also understand I may be responsible for any and all amounts not payable by my insurance company including any portion paid and not applied to in network benefits for any out of network services, non covered services, services determined by the insurer as not medically necessary, or any failure by my insurer to comply with all governing and applicable laws. I agree to cooperate with all providers listed in this agreement in any attempts by such provider to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with provider against such insurers and/or employee health care plan for failure to pay all entitled benefits or provide all protected rights.

Thereby irrevocably, designate, authorize and appoint the Provider listed above or any appointed business associate as assigned by the provider as my true and lawful attorney-in-fact. This power of attorney is hereby provided for the limited purpose of assuring receipt of all entitled benefit payments, rights of appeal, disclosure and remedies due under my governing Health and Welfare or Federal Healthcare plan or Policy to include all medical services rendered or to be rendered as ordered by the provider listed above. This power of attorney shall automatically terminate, without formal action being taken, as soon as the above listed healthcare provider/s has received payment in full and all rights as entitled under my governing Plan and in full compliance of governing federal and state laws. I hereby confirm and ratify all actions taken by my attorney-in-fact pursuant to the authority granted herein. I hereby authorize my Plan and insurer unequivocal assignment and transfer of all entitled plan benefits, all rights under the Plan and federal law of appeal, disclosure, remedies and litigation due me to the Provider listed above and any appointed business associates working with them for the sole purpose of making sure all entitled benefits and rights under my specific health and welfare plan of governing law are administered in full compliance and to the extent of governing law. This authorization includes all protected rights under applicable governing law to receive entitled benefits, submittal of evidence, receive requested disclosures, to give or receive any notice related to benefits and rights, receive copies of all relevant documents and data pertaining to my claim and appeal submittals, receive governing plan documents, remedies, request administrative reviews, litigation, or make any statement of fact and law on my behalf to the extent consistent with Federal and state law. This is a direct unequivocal assignment of all rights and benefits under the governing plan/policy/Social Security Act. I understand this payment will not exceed my indeptedness 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 where entitled benefits applicable to governing federal and state laws are paid. I hereby instruct and direct my Plan or Health Insurance Issuer to pay all entitled plan benefits as required by the governing Plan/Policy directly to any applicable Provider(s) listed above following all terms, conditions and requirements of the governing Health and Welfare Plan. I understand under applicable governing law that I have the right and authority to direct where payment for services rendered is sent. If my current policy prohibits direct payment to the provider of service, I under my protected rights pursuant to applicable state, federal or ERSIA law hereby instruct and direct my Insurance Company to provide specific SPD documentation stating such non-assign ability clause to myself and the applicable Provider, along with the regulatory guideline that allows for such non-assignability. Upon proof of specified non-assignability documentation, I then instruct that the insurer make the check out to me and mail it directly to the Provider and address listed on the submitted claim for the professional or medical expense benefits, and otherwise payable to me under my current insurance policy as payment towards the total charges for the professional services rendered. I agree and understand that any funds received by my insurance company due for services rendered by any and all healthcare providers listed in this assignment of benefits will be immediately signed over and sent directly to such provider. Upon receipt of said check, I authorize Provider listed above to receive any such checks, endorse them for deposit only, and to deposit and apply all proceeds toward payment due on my account. I authorize the release of any information pertinent to my case including any and all medical records required for a full and fair review to any business associate, insurance company, adjuster, Plan Sponsor, Plan Administrator, governmental agency or attorney involved or responsible for making sure all protected rights and entitled benefits are provided. I authorize duly authorized representative to initiate formal complaints to any State or Federal agency that has jurisdiction over my insurer and/or plan benefits. Should the account be referred to an attorney or outside agency for collection, the undersigned shall pay reasonable attorney's fees and collection expenses. I understand that all delinquent accounts bear interest or administrative fees at the legal rate. I also agree that any penalties or fines levied against my insurance company will be paid to the Provider acting as my personal representative. I understand that this assignment will remain in effect until revoked by me in writing except to the extent that the covered entity has already used or disclosed information under the authorization or (b) if the authorization was obtained as a condition of insurance coverage, or other law that provides the insured with the right to contest a claim under the governing Plan/policy. A photocopy of this Assignment shall be considered as effective and valid as the original.

_____ _____ _____

Signature of Patient/Guarantor Full Address (Required by Some Insurance Plans) Date