ENGLEWOOD SPORTS MEDICINE ORTHOPAEDIC SURGERY, P.C.

ASSIGNMENT OF BENEFITS/ ERISA AUTHORIZED REPRESENTATIVE FORM

FINANCIAL RESPONSIBILITY

I have requested professional services from **Englewood Sports Medicine Orthopaedic Surgery, P.C. ("ESMOS")** on behalf of myself and/or my dependents, and understand that by making this request, I am responsible for all charges incurred during the course of said services. I understand that all fees for said services are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement unless other arrangements have been made in advance.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign all applicable health insurance benefits for which I and/or my dependents are entitled to **ESMOS**. I certify that the health insurance information that I provided to ESMOS is accurate as of the date set forth below and that I am responsible for keeping it updated.

I hereby authorize ESMOS to submit claims, on my and/or on my dependents behalf, to the benefits plan (or its administrator) listed on the current insurance card I provided to ESMOS in good faith. I also hereby instruct my benefits plan (or its administrator) to pay ESMOS directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to the Provider, I hereby instruct and direct my benefits plan (or its administrator) to provide documentation stating such non-assignments to myself and ESMOS upon request. Upon proof of such non-assignment, I instruct my benefits plan (or its administrator) to make out the check to me and will mail it directly to ESMOS.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from ESMOS are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including copayments, co-insurance and deductibles.

ASSIGNMENT OF MOTOR VEHICLE BENEFITS

I irrevocably authorize **ESMOS** to obtain counsel and enter legal or other action on my behalf and/or in my name, including the arbitration/dispute resolution process, to collect such sums due it shoud sums not be paid within the legally prescribed time frame. In the event that ESMOS elects to bring a lawsuit or petition for Arbitration/Dispute resolutions against the insurance carrier, I irrevocably assign my rights title, and interest under the medical expense benefits and/or PIP section of the insurance policy attorney of ESMOS choosing to bring suit or submit to for injuries that I sustained in this or any accident.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize **ESMOS** to 1 release any information necessary to my health benefits plan (or its administrator) regarding my illness and treatments: 2 process insurance claims generated in the course of examination or treatment: and 3 allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

ERISA AUTHORIZATION

I hereby designate, authorize and convey to **ESMOS** to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: 1 the right and ability to act as my Authorized Representative in connection with any claim, right and ability to act as my Authorized Representative to pursue such claim, right or cause in action that I may have under such insurance policy and/or benefits plan: and 2 the right and ability to act as my Authorized Representative to pursue such claim, right or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right and ability to act as my Authorized Representative with respect to a benefits plan governed by the provision of ERISA as provided in 29 C.F.R. § 2560.5031(b)(4) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims or reimbursement, any other applicable remedy, including fines.

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

PATIENT NAME (PLEASE PRINT)

PATIENT SIGNATURE

DATE