Offices in Crestview and Pensacola
Office: (850) 356-4407
Fax: (850) 807-5487
E-mail: orthospineinstititute1@gmail.com
Website: roberthuangmd.com

ASSIGNMENT OF BENEFITS & LIMITED POWER OF ATTORNEY

I, _____ irrevocably assign to you, Orthopaedic Institute of Northwest Florida, a dba of Children's Orthopaedic Institute of Northwest Florida, LLC, my medical provider, all my rights and benefits under my insurance contract and/or any employee welfare benefit plan for payment for services rendered to me, but not limited to all my rights under the Employee Retirement Income Security Act ("ERISA") applicable to the medical services at issue. I irrevocably authorize you to file insurance claims on my behalf against the PIP carrier/health care carrier/employee welfare benefit plan for any and all rights under ERISA or applicable statute/law, including but not limited to the claim for penalties and fees under ERISA for failure to provide Plan Documents. I irrevocably authorize you to retain an attorney of your choice on my behalf for collection of your bills and/or to file insurance claims on my behalf for services rendered to me. I direct that all reimbursable medical payments go directly to you, my medical provider. I authorize and consent to your acting on my behalf in this regard and in regard to my general health insurance coverage and I especially authorize you to pursue any administrative appeals conducted pursuant to ERISA, including but not limited to the authority to request and/or receive applicable Plan Documents.

In the event the insurance carrier responsible for making medical payments in this matter doesn't accept my assignment, or my assignment is challenged or deemed invalid, I execute this limited/special power of attorney and appoint and authorize your collection attorney as my agent and attorney to collect payment for your medical services directly against the carrier in this case, in my name, including filing an arbitration demand or lawsuit. I specifically authorize that attorney to file directly against that carrier in my name or in your name as a medical provider rendering services to me and designate your collection attorney as my attorney-in-fact. I further grant limited power of attorney to you as my medical provider to receive and collect directly from the insurance carrier money due you for services rendered to me in this matter, and hereby instruct the insurance carrier to pay you directly any monies due you for medical services you rendered to me. I authorize you and your attorney to receive from my insurer, immediately upon verbal request, all information regarding last payment made by said insurer on my claim, including date of payment and balance of benefits remaining.

I authorize you and your attorney to obtain and release medical information regarding my physical condition to and from third parties including, but not limited to, health care provider(s), hospitals, diagnostic centers, insurers, etc., and I especially authorize such third parties to release such information to you about me, including medical reports, X-ray reports, narrative reports, and any other report or information regarding my physical condition.

Patient, Parent, or Legal Guardian: _____

Signature: _____

Date: _____

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Authorization/Consent Acknowledgment

RELEASE OF INFORMATION:

I acknowledge that records concerning the patient are the property of Orthopaedic Institute of Northwest Florida, a dba of Children's Orthopaedic Institute of Northwest Florida, LLC, and are maintained for the use and benefit of Orthopaedic Institute of Northwest Florida and its staff in providing care and treatment to the patient. I hereby authorize Orthopaedic Institute of Northwest Florida to disclose all or any part of my patient record to my referring physician, primary care physician, admitting physician, consulting physician, and/or hospital based physician.

I further authorize Orthopaedic Institute of Northwest Florida and providing physicians to disclose all or any part of my patient record to any person or corporation which is or may be liable under contract to Orthopaedic Institute of Northwest Florida, myself or a family member of mine, for all or part of Orthopaedic Institute of Northwest Florida charges, including but not limited to, hospital or medical service companies, insurance companies, Worker's Compensation carriers, welfare agencies, or my employer, provided such release of information shall be in accordance with state and federal laws and regulations.

COLLECTION PROCESS:

In the event that an account is referred to an outside collection agency and/or small claims suit, that responsible party will be subject to paying any/all fees associated with the collection processes. I hereby authorize Orthopaedic Institute of Northwest Florida to obtain a credit history for such collection purposes. In the event that our office must commence legal action against the patient for payment of the patient's balance, the patient agrees to be liable for attorney fees and costs incurred by the office as part of such action and any attorney fees and costs incurred by this office in order to recover on the resulting judgment. I acknowledge a fee of $50 for any returned checks.

You agree, in order for us to service your account or to collect monies you may owe, Orthopaedic Institute of Northwest Florida, and/or agents may contact you by the telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email addresses you provide to use. Methods of contact may include using prerecorded/artificial voice messages and/or use of automatic dialing services as applicable. I/We have read this disclosure and agree that Orthopaedic Institute of Northwest Florida, its employees and/or agents may contact me/us as described above.

Patient, Parent, or Legal Guardian: _____

Signature: _____

Date: _____

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AUTHORIZATION FOR MEDICAL CARE AND TREATMENT:

I. I recognize that a medical condition may exists requiring medical care and I voluntarily consent to such medical care, treatment and diagnostic procedures by Orthopaedic Institute of Northwest Florida and its medical and professional staffs, associates and agents as deemed necessary.

II. I hereby authorize my physician, as provided by law to furnish medical treatment, diagnostic procedures, x-ray/MRI diagnosis or therapy as he/she considers necessary and proper in the treatment process.

III. I am aware that the practice of medicine and surgery, and the administration of medical care, are not exact sciences and I acknowledge that no guarantees have been made to me as to the result of diagnostic procedures, treatments, examinations or care undertaken with Orthopaedic Institute of Northwest Florida.

ACKNOWLEDGMENT OF HEALTH INFORMATION PRACTICES

Orthopaedic Institute of Northwest Florida Notice of Privacy Practices provides information about how health information about patients may be used and disclosed. I have been offered and opportunity to review the Notice of Privacy Practices before signing this consent. I understand the terms of the Notice may change and that a copy of the revised Notice will be posted at all of Orthopaedic Institute of Northwest Florida facilities. By signing this form, I acknowledge that I have been offered and/or received Orthopaedic Institute of Northwest Florida Notice of Privacy Practices.

The contents of the form have been fully explained to me and I have been given the opportunity to ask questions. Any questions that I have asked have been answered to my satisfaction. I certify that I understand the contents of this form in its entirety.

Termination of care may result from failure to cooperate and/or comply with Orthopaedic Institute of Northwest Florida Policy and Procedures as well as failure to cooperate and/or comply with medical care and/or treatment deemed necessary by Orthopaedic Institute of Northwest Florida physicians and medical staff.

I understand and agree to the above mentioned.

Patient, Parent, or Legal Guardian: _____

Signature: _____

Date: _____