**ASSIGNMENT OF BENEFITS & ASSIGNMENT OF RIGHTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (“ERISA”)**

**FINANCIAL RESPONSIBILITY**

**I have requested professional services from Advanced Surgery Center, LLC (Provider) 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 I agree to pay all such charges in full immediately upon presentation of the appropriate statement, unless other arrangements have been consented to in advance by the Provider.**

**ASSIGNMENT OF BENEFITS**

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

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

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

**AUTHORIZATION TO OBTAIN, RELEASE, AND DISCLOSE INFORMATION I hereby authorize and give Provider right to: (1) release any information necessary to my health benefit plan, its agents, and/or its administrator(s) regarding my illness and treatments; (2) obtain any plan information or other documents to which I may be entitled to the same extent as me; (3) process and submit insurance claims generated in the course of examination and/or treatment; and (4) allow a photocopy of my signature to be used to process insurance claims.**

**ERISA AUTHORIZATION I hereby designate, authorize and convey to Provider to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan, as my duly Authorized Representative, the right and ability to: (1) act on my behalf in connection with any claim, right or cause in action that I may have under such insurance policy and/or benefit plan; (2) act on my behalf 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 to act on my behalf with respect to a benefit plan governed by the provisions of ERISA) regarding any healthcare expenses incurred as a result of the services I received from Provider; and (3) claim on my behalf such benefits, claims or reimbursement, and any other applicable remedy, including fines and civil penalties, to which I may otherwise be entitled.**

**This order will remain in effect until revoked by me in writing. Unless expressly revoked, this assignment and authorization is valid for ALL administrative and/or judicial reviews under ERISA, PPACA, Medicare, and applicable federal and state laws.**

**A photocopy of this assignment/authorization shall be as effective and valid as the original.**

**Patient (Responsible Party) Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Printed Name of Policyholder/Insured\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**