HOUSTON METRO ORTHO AND SPINE SURGERY CENTER

ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND/OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

I hereby assign and convey directly to the above-named health care provider, as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by the above-named health care provider, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above-named health care provider to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named health care provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named health care provider or its attorneys in order to claim such medical benefits.

In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to the above named health care provider any legal or administrative claim or chose an action arising under any group health plan, employee benefits plan, health insurance or tort feasor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the above-named health care provider (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to the above-named provider all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or mediations provided by the above-named health care provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (above-named provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original.

I have presented my insurance card and photo identification and I recognize that my attending physician, consulting physician, anesthesiologist, radiologist, ER physician, professional laboratory and pathological services are independent contractors and will generate separate bills for their respective services. I understand I am financially responsible for their fees.

Medicare Payments – (Patient's Certification, Authorization to Release Information and Payment Request) I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to related to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim.

Personal Valuables Authorization – I have been informed and understand that the facility WILL NOT ASSUME RESPONSIBILITY for any personal property I may bring and/or keep in the facility during my stay at Elite Center for Minimally Invasive Surgery.

Advanced Medical Directive/Patient Rights and Responsibilities – I have been given written materials about my right to accept or refuse medical treatments and have been informed of my rights to formulate Advanced Directives ___ yes ___ no. I also acknowledge receipt of a written statement regarding my rights and responsibilities as a patient, which tells me how to register any complaint that I might have.

Conditions of Coverage Documents – I have been presented the required Conditions of Coverage Documents.

Accidental Exposure of Health Care Worker – I understand and acknowledgement that Texas Law provides that if any health care worker is exposed to my blood or other bodily fluid, the facility may perform tests, with or without my consent, on my blood or other bodily fluid to determine the presence of any communicable disease, including but not limited to Hepatitis, Human Immunodeficiency Virus (the causative agent of AIDS) and Syphilis. I understand that the results of tests taken under these circumstances are confidential and do not become part of my medical record.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

Patient Signature	Date
Witness Signature	Date

PLY 1 – ORIGINAL PLY 2 – COPY