1960 FAMILY PRACTICE 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 billing 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 billing 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 billing 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 billing provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named health care billing provider or its attorneys in order to claim such medical benefits.

I intend by this assignment and designation of authorized representative to convey to the above-named billing 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 billing 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 billing 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.

1960 FAMILY PRACTICE Financial Policy/ Patient Statement

Thank you for choosing us for your healthcare needs. Pursuant to the provisions of the Patient Protection and Affordable Care Act, we are committed to ensuring that you receive the highest quality care at an affordable price. Further, we want to protect our patients from unexpected bills. To make our services available to as many patients as possible on an affordable basis, we have adopted the financial policy outlined below. We ask you to read the policy carefully and sign prior to any treatment.

- WE MAY ACCEPT ANY ASSIGNABLE INSURANCE WITH APPLICABLE COVERAGE.
- WE MAY OFFER FINANCIAL ASSISTANCE UNDER OUR FINANCIAL POLICY TO ELIGIBLE PATIENTS ON A CASE BY CASE BASIS.

Insurance
We accept assignment of insurance benefits at our discretion if acceptable insurance identification is provided. Acceptable insurance identification is defined as a valid insurance card, policy/plan with applicable coverage, and telephone/online verification. As a courtesy to our patients, verifiable and assignable insurance will be billed by our office. However, you are personally responsible for your account balance in the event your insurance company does not pay the full amount of your claims, unless you are eligible for a reduction in the amount owed under our Financial Policy.

Discounts or Reductions in Bill
We may offer a discount, reduction or waiver of the deductible, coinsurance or co-pay to eligible patients based on medical needs and ability to pay on a case-by-case basis under our Financial Policy in accordance with applicable federal and state laws.

Your Responsibility and Cooperation
If we accept your insurance assignment as a payment from your insurance company, you agree to timely cooperate with your insurance company or health plan in the course of insurance claim processing, such as insurance inquiries, requests for additional information, claims status verification or any inquiries for the purpose of your claim processing. You also agree to notify us immediately of any insurance inquiry or request for additional information and provide us with a copy of any documentation received from the insurance company or submitted to the insurance company from you.

We are committed to providing you with the highest quality care possible at an affordable cost. Every staff member at our office is ready to help you at any time.
If you have any questions regarding our financial policies, please do not hesitate to ask us at any time.
I have read the Financial Policy. I understand and agree to this Financial Policy.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT

X _____ _____ _____
Signature of Patient or Responsible Party | Patient Name (print) | Date

X _____ _____ _____
Signature of Co-Responsible Party | Your Name (print) | Date