The Spine Center of Southeast Georgia

A PROSPIRA PAINCARE CENTER OF EXCELLENCE

Assignment of Benefits Form & Release
The Spine Center of Southeast Georgia

I, the undersigned, hereby authorize the assignment of the benefits and rights available to me under my insurance plan with the insurance company listed on the copy of the current insurance card I have provided to The Spine Center of Southeast Georgia (hereinafter "Spine Center") for medical services and care provided to me by the Spine Center. I hereby authorize payment be made directly to the Spine Center for all my covered health insurance benefits from all Third Party payers, including my employer in the event of a Worker's Compensation case. I further understand that I am financially responsible for services denied as non-covered. I certify that the insurance information I have provided to the Spine Center is true and accurate and that I am responsible for keeping said information updated. I am fully aware that having health insurance does not absolve me of my responsibility to ensure that the charges for the professional services and care rendered to me by the Spine Center (hereinafter "charges") are paid in full. I also understand that my insurance company may not pay at 100% of the amount of the charges and that I may be responsible for any and all charges not paid to the Spine Center by my insurance company, including any portion paid and not applied to in-network benefits for any out-of-network services. **I agree to pay the full amount of any and all charges pursuant to the Spine Center's scheduled rates, copies of which are available to me upon request prior to treatment.**

I authorize the Spine Center to release (1) information necessary to secure payment of benefits and/or (2) records of any treatment or examination rendered to me to other medical providers. This information may relate to (a) age; (b) medical history, condition, and/or care; (c) physical and/or mental health; (d) occupation; (e) income; (f) avocations; (g) driving records; and/or (h) other personal characteristics. This authorization extends to information on the use of alcohol, drugs and/or tobacco; the diagnosis and/or treatment of HIV infection and other sexually transmitted disease(s); and the diagnosis and/or treatment of mental illness.

I authorize the Spine Center to submit claims on my behalf to my insurance company. I fully agree and understand that the submission of a claim does not absolve me of my responsibility to ensure that all charges are paid in full. I authorize the use of this signature on all of my insurance submissions, whether manual or electronic.

I irrevocably designate, authorize and appoint the Spine Center as my true and lawful attorney-in-fact. This power of attorney is provided for the limited purpose of receiving all payments due under my insurance plan on account of medical services and care rendered or to be rendered to me by the Spine Center. I hereby confirm and ratify all actions taken by my attorney-in-fact pursuant to the authority granted herein. I authorize my insurance company to assign and transfer any and all of my applicable plan benefits and rights to the Spine Center, including the right to receive any applicable plan documents and remedies and to pursue appeals and/or litigation on my behalf. This authorization includes any rights due me permissible under state and federal laws and is valid for a period of one year.

I instruct and direct my insurance company to pay the Spine Center directly. This includes any event where the Spine Center may be Out of Network. I understand that under ERISA, I have the right and authority to direct where payment for services rendered is sent. If my current policy prohibits direct payment to the Spine Center; under my rights per state and federal ERISA regulations, I instruct and direct my insurance company to provide SPD documentation stating such non-assignability clause to me and the Spine Center. Upon proof of non-assignability, I instruct my insurance company to make the check out to me and mail it directly to the Spine Center for the professional and/or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment towards the total charges. I agree and understand that any funds I receive from my insurance company for services and care rendered by the Spine Center will be immediately signed over and sent directly to the Spine Center. If my insurance company sends a check for payment directly to me, I agree to immediately deliver the check to the Spine Center, as I understand that the Spine Center has the right to immediate possession of the check.

This is a direct assignment of my rights and benefits under my insurance policy. I have agreed to pay any balance of the charges over and above any such insurance payment. I authorize the Spine Center to receive any checks from my insurance company on my account, endorse them for deposit, and deposit and apply the proceeds toward payment on my account. I further authorize the Spine Center to deposit checks received on my account when made out to me.

I authorize the release of any information pertinent to my case to any insurance company, adjuster, and/or attorney involved in this case. I authorize the Spine Center to be my personal representative, which allows it to: (1) submit any and all appeals when my insurance company denies me benefits to which I am entitled; (2) submit any and all requests for benefit information from my insurance company; and (3) initiate formal complaints to any state and/or federal agency that has jurisdiction over my benefits.

I understand and agree that I am responsible for full payment of the total charges if my insurance company has refused to pay 100% of my benefits based on billed charges within ninety days of any and all appeals or requests for information. Should my account be referred to an attorney or outside agency for collection, I agree to pay to the Spine Center reasonably attorneys' fees and collection expenses. All delinquent accounts shall bear interest at the maximum rate of 1½ percent per month under O.C.G.A. § 7-4-16, or the highest legally available rate, whichever is higher. I understand and agree that fines levied against my insurance company will be paid to the Spine Center for acting as my personal representative.

I authorize the Spine Center and its associates to provide medical care and treatment to me by today's standards. Any action stemming from this Assignment of Benefits Form & Release shall be instituted, prosecuted, and maintained in Glynn County, Georgia. A photocopy of this Assignment of Benefits Form & Release shall be considered as effective and valid as the original. If any part or provision of this Assignment of Benefits Form & Release should be held void or invalid, the remaining provisions shall remain in full force and effect.

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Signature of Patient/Guarantor Date

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Signature witnessed by Date