ASSIGNMENT OF BENEFITS, LIMITED POWER OF ATTORNEY, AND APPOINTMENT OF REPRESENTATIVE

I_________________________________(Print Name) with insurance benefits through ________________________ (Employer Name, Medicare, Medicaid or Individual Plan) hereby *authorize benefits to be assigned to* **Midtown Foot Clinic, PC and Midtown Surgical Center, LLC,** for healthcare services provided to me by **Midtown Foot Clinic, PC and Midtown Surgical Center, LLC**. I hereby certify that the insurance information that I have provided **Midtown Foot Clinic, PC and Midtown Surgical Center, LLC** is true and accurate as of the date of service and that I am responsible for keeping it updated. I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my medical bill is paid in full. I also understand that my insurance company may not pay 100% of the amount of the medical claim and I may be responsible for any and all amounts not payable by my insurance company including any portion paid and not applied to in network benefits for any out of network services.

I hereby authorize **Midtown Foot Clinic, PC and Midtown Surgical Center, LLC** to submit claims, on my behalf, to the insurance company providing benefits and provided to **Midtown Foot Clinic, PC and Midtown Surgical Center, LLC**, in good faith. I fully agree and understand that the submission of a claim does not absolve me of my responsibility to ensure the claim is paid in full

I hereby *irrevocably, designate, authorize and appoint* **Midtown Foot Clinic, PC and Midtown Surgical Center, LLC** as my *true and lawful attorney-in-fac*t. This power of attorney is hereby provided for the limited purpose of receiving all payments due under my policy/medical care plan on account of medical services and care rendered or to be rendered. This power of attorney shall automatically terminate, without formal action being taken, as soon as **Midtown Foot Clinic, PC and Midtown Surgical Center, LLC** has received payment in full and all remedies due under applicable regulatory guidelines for all medical care services provided or requested. I hereby confirm and ratify all actions taken by my attorney-in-fact pursuant to the authority granted herein. I authorize the release of any medical records required to obtain a full and fair review and all protected rights of appeal.

I hereby *appoint as representative* ***Midtown Foot Clinic, PC and Midtown Surgical Center, LLC*** *and authorize my insurer to assign and transfer any and all applicable plan benefits and rights to* **Midtown Foot Clinic, PC and Midtown Surgical Center, LLC** and any appointed business associates working with them for the sole purpose of making sure all protected rights and benefits under my plan or applicable Social Security Act, as well as any Federal, City or State government program are administered accurately, *including but not limited to the right to receive any applicable relevant documents pertaining to adverse benefit determination, relevant plan documents/remedies, disclosures, pursue appeals, administrative reviews and litigation on my behalf. This authorization includes any and all entitled benefits, protected rights and remedies permissible under state, federal laws or applicable Social Security Act. This is a direct assignment of my rights and benefits under any governing healthcare plan/policy.* This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. Upon receipt of said check, I authorize **Midtown Foot Clinic, PC and Midtown Surgical Center, LLC** to receive any such checks, endorse them for deposit only, and to deposit and apply all the proceeds toward payment on my account.

I hereby instruct and direct my Insurance Company to pay all entitled plan benefits at the stated plan benefit level directly to **Midtown Foot Clinic, PC and Midtown Surgical Center, LLC** for all services rendered by **Midtown Foot Clinic, PC and Midtown Surgical Center, LLC**. I understand under applicable ERISA, state and/or federal regulatory guidelines that I have the right and authority to direct where payment for services rendered is sent. If my current policy prohibits direct payment to the provider of service, I under my rights per state and federal ERSIA regulations hereby instruct and direct my Insurance Company to provide SPD documentation stating such non-assign ability clause to myself and **Midtown Foot Clinic, PC and Midtown Surgical Center, LLC**. Upon proof of non-assign ability documentation I then instruct that the insurer make out the check to me and mail it directly to the Provider and address listed on the submitted claim for the professional or medical expense benefits, and otherwise payable to me under my current insurance policy as payment towards the total charges for the professional services rendered. I agree and understand that any funds received by my insurance company due for services rendered by **Midtown Foot Clinic, PC and Midtown Surgical Center, LLC** will be immediately signed over and sent directly to **Midtown Foot Clinic, PC and Midtown Surgical Center, LLC**.

I authorize the release of any medical or other information pertinent to my case to any insurance company, Plan/Benefits Administrator, adjuster, or attorney involved in this case. I authorize **Midtown Foot Clinic, PC and Midtown Surgical Center, LLC** or appointed business associates to be my personal representative, which allows them as *my legally binding authorized representative* 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 or Federal agency that has jurisdiction over my insurer and/or benefits. I fully understand and agree that I am responsible for full payment of the medical debt if my insurance company has refused to pay 100% of my stated plan benefits based on billed charges, within ninety (90) days of any and all appeals or request for information. Should the account be referred to an attorney or outside agency for collection, the undersigned shall pay reasonable attorney's fees and collection expenses. All delinquent accounts bear interest at the legal rate. I also agree that any fines levied against my insurance company will be paid to **Midtown Foot Clinic, PC and Midtown Surgical Center, LLC** for acting as my personal representative.

I authorize **Midtown Foot Clinic, PC and Midtown Surgical Center, LLC** and its associates to provide medical care reasonable by today's standards.

A photocopy of this Assignment shall be considered as effective and valid as the original.

X____ ____________________________

Signature of Patient or Authorized Person **Date**