LEGAL ASSIGNMENT OF BENEFITS AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

I, the undersigned, have insurance and/or employee health care benefits coverage and for good and valuable consideration, I hereby appoint the healthcare provider, Best Choice Anesthesia and Pain Services, as my designated Authorized Representative(s). In addition, I hereby assign and convey directly to the above named healthcare provider(s), all medical benefits and/or insurance reimbursements, if any, otherwise payable to me for services rendered from such provider(s), regardless of such provider's managed care network participation status. I understand and agree that I am legally responsible for the actual total charges expressly authorized by me regardless of any applicable insurance or benefit payments. I hereby grant the above named provider(s) authority under HIPAA, to release all medical information necessary to process my health claims. I hereby authorize any plan administrator, plan fiduciary and/or insurer and to release to such provider(s) any and all insurance plan documents and a copy of my health insurance policy upon request. I also authorize my provider permission to use my signature on all health insurance and/or employee health benefits claim submissions.

To the full extent permissible under the law, including but not limited to, ERISA §502(a)(1)(B) and §502(a)(3), I assign and convey to the above named provider(s), my benefits in any applicable employee group health plan(s), individual health insurance policy, personal injury protection policy, medical payments policy, underinsured/underinsured motorist policy, third party tort recovery, in order to satisfy any and all medical expenses legally incurred by me for medical services I received from the above named provider(s). Furthermore, to the full extent permissible under the law, I grant to the provider, a lien on such medical benefits, settlement, proceed and/or insurance reimbursements.

Lastly, I grant the provider authority to; (1) obtain information about the claim to the same extent as the assignor; (2) submit evidence and information on my behalf; (3) make statements about facts or law, if known; (4) make requests, give or receive any notice about appeal proceedings; and (5) take any administrative, legal and judicial action including filing suit, in my name with derivative standing, which the provider deems necessary to obtain payment of my health insurance benefits. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal or state laws. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement. The foregoing shall not be construed as an obligation of this medical provider to pursue any legal appeal or legal recovery.

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Signature of Insured/Guardian Date