

Name \_\_\_\_\_ Date \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Social Security No \_\_\_\_\_

Demographics  Male  Female  Other  Single  Married  Divorced  Widowed

Reason for your Visit \_\_\_\_\_

Who referred you to this office?  Doctor  Patient  Web Site  Other

Please elaborate (name and phone) \_\_\_\_\_

If your visit pertains to an injury, what was the date \_\_\_\_\_

Preferred Language  English  Spanish  Other \_\_\_\_\_

Ethnicity  Hispanic/Latino  Not Hispanic/Latino

Race  American Indian/Alaskan  Asian  African American  Native Hawaiian/Pacific  Other  White

Email \_\_\_\_\_ Cell # \_\_\_\_\_ Home # \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Phone # \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Co. (primary) \_\_\_\_\_ (secondary) \_\_\_\_\_

Guarantor (Name of Person who is the Primary Insured) \_\_\_\_\_

Guarantor's date of birth \_\_\_\_\_ SS# \_\_\_\_\_ Relationship \_\_\_\_\_ (needed for insurance submission)

Who is responsible for payment?  Patient  Guarantor (  Check here if guarantor is a parent)  Other \_\_\_\_\_

Primary Care Physician (name and location): \_\_\_\_\_

Pharmacy (name and location): \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Today's Date \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Please approximate your blood pressure (i.e. 120/80) \_\_\_\_\_

Any RECENT fever, chills or unintended weight loss? Yes No

Problems with your Heart (previous heart attack)? Yes No

Problems with your Breathing (asthma, shortness of breath)? Yes No

Do you have Obstructive Sleep Apnea? Yes No Do you use a CPAP machine? Yes No

Have you ever had a Blood Clot (DVT) in your legs? Yes No

Have you ever had excessive bleeding from surgery? Yes No

Have you ever had a complication from surgery? Yes No

Please explain \_\_\_\_\_

Have you ever had a complication from anesthesia (not including nausea / vomiting)? Yes No

Have you ever received a blood transfusion? Yes No

Did you have any metal implant? (where \_\_\_\_\_) Yes No

Do you smoke? Never Quit Few cigs/day 1/2 pack 1 pack > 1 pack/day

Do you drink Alcohol / Beer / Wine? No Yes (if yes, please select social few/week heavy)

**Current Medications** No Yes (if yes, list name and dosage) \_\_\_\_\_

**Allergies to Medicine (or latex)?** No Yes (what happens?) \_\_\_\_\_

**Do you take Blood Thinners?** No Baby Aspirin Full Aspirin Coumadin Eliquis

Pradaxa Savaysa Xarelto Lovenox Plavix Other \_\_\_\_\_

**Do you take supplements?** No Dong Quai Ginger Ginkgo Biloba Vitamin E Garlic

Ginseng Omega-3 fatty acid Feverfew Other (names / dosages) \_\_\_\_\_

**Current Medical Conditions (check all that apply)**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> <b>NONE</b>                 | <input type="checkbox"/> COPD (emphysema)         | <input type="checkbox"/> Kidney Failure - Dialysis |
| <input type="checkbox"/> Anxiety                     | <input type="checkbox"/> COVID-19                 | <input type="checkbox"/> Migraines                 |
| <input type="checkbox"/> Asthma                      | <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Mitral Valve Prolapse     |
| <input type="checkbox"/> A-fib (atrial fibrillation) | <input type="checkbox"/> Glaucoma                 | <input type="checkbox"/> MRSA (Staph infection)    |
| <input type="checkbox"/> Bleeding Problems           | <input type="checkbox"/> Heart Attack ("MI")      | <input type="checkbox"/> Rheumatoid Arthritis      |
| <input type="checkbox"/> Cancer (explain below)      | <input type="checkbox"/> Heart (coronary) Disease | <input type="checkbox"/> Seizures                  |
| <input type="checkbox"/> CHF (heart failure)         | <input type="checkbox"/> Hepatitis or HIV         | <input type="checkbox"/> Stroke (or TIA)           |
| <input type="checkbox"/> Cholesterol (high)          | <input type="checkbox"/> High Blood Pressure      | <input type="checkbox"/> Thyroid (low)             |

**Other Medical**

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**Previous Surgery**    No    Yes (please explain)

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**Family History**    No    Yes (please explain)

Cancer    Heart Disease    Bleeding Problems    Other \_\_\_\_\_

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**Have you recently experienced any of the following (you may underline or circle)?**

- Constitutional: Recent fevers or unexplained weight loss
- Head-Neck: Recent vision changes, dry eyes or irritation, nasal problems, or neck pain
- Heart: Recent chest pain, palpitations, a need to take nitroglycerin under your tongue, or angina
- Lungs: Recent shortness of breath, cough, or difficulty breathing
- Hematology: Easy bruising, difficulty clotting, very heavy periods, or frequent and/or excessive nose bleeds
- GI: Recent stomach pains / nausea / vomiting / GI problems
- Skin: Unexplained rashes, difficulty healing, wounds that won't heal, or skin cancer concern
- Neuro: Recent headaches, dizziness, or poor balance
- Hand: Change in fingertip feeling, weakness, dropping things unexpectedly
- Musculoskeletal: Neuropathy, pain in calves when walking

### Terms and Conditions

The following paragraphs contain information about your rights and the care you receive. READ THEM CAREFULLY. It is our goal to provide you with the highest level of care. To do so requires your fullest cooperation. For the purposes of this document, the term "providers" refers to Associates in Plastic & Aesthetic Surgery PA, Jerrold Zeitels MD, Richard Tepper MD and/or Westfield Plastic Surgery Center LLC. This form cannot be altered. Hand-written notations of any kind are invalid. Your signature is required in order to receive care from "providers" and by signing, you are agreeing to information found below.

Infection Control: Staff members are educated about proper infection control techniques. We stay apprised of State and CDC guidelines. If you feel ill or have viral symptoms, please inform us so your appointment can be changed. While we make efforts to prevent infections, we cannot guarantee that you won't be exposed to one.

Notice of Privacy Practice: THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. State and Federal Laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will remain in effect until it is amended or replaced by us. It is our right to change our privacy practices provided law permits the changes and we will make the new notice available upon request. Any changes will be applicable to information obtained prior the change. You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer. Information on contacting us can be found at the end of this Notice.

HIPAA - Uses and Disclosures of Protected Health Information: We will keep your health information confidential. We may use it without consent for the following purposes: Treatment, Payment or Health Care Operations. We have established "minimum necessary" standards that limit various staff members' access to your health information according to their primary job functions. We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or services to you. Health information about you may also be disclosed to your family or other persons but only with your written consent below. "Providers" and their business associates may use and disclose your health information to seek payment for services provided to you, to notify anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. We will also use our professional judgment to make reasonable inferences about your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised otherwise. We may disclose health information to keep our practice operable or as required by law (court or administrative orders, subpoena, discovery request or other lawful process), when requested by national security, intelligence and other State and Federal officials, if we reasonably believe that you are a possible victim of abuse or other crime, and/or or public health matters such as reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability. We may use your email and/or mobile number to notify you about an upcoming appointment, advise you of general practice information, and/or inform you of new procedures and cosmetic services, also known as "marketing". However, we will not use your specific health information for targeted marketing purposes. We may use your email or mobile number to request reviews from you. We may use email, phone, messaging (text / iMessage) and/or postal mail for appointment reminders and other practice notices.

Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are legal guardian). There may be some limited exceptions. If you wish to examine your health information, please submit a written request to our office. Once approved, an appointment can be made to review your records. If you request a copy of your record, a fee will be assessed of \$1.00 per page along with applicable postage. A signed consent is required. If your request is limited in scope (i.e. a copy of a note or lab report), it is generally accepted that limited releases are permitted even without signing an actual release form. If you email us with such a request and we feel it is reasonable and limited in scope, we will try and comply. By emailing us, you are giving us permission to reply and send the requested information, even if such contains "protected information." Please note that our emails are not encrypted. Do NOT rely on email for clinical questions of any significance / urgency. If you have a medical emergency, call 911 or go to the nearest emergency room. You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances your request may be denied. You have a right to receive a list of non-routine disclosures we have made of your health care information. When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of such. You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement. Please contact our Privacy Officer. You have the right to file a complaint if you feel we have not complied with our Privacy Policies. Your complaint should first be directed to our Privacy Officer. If you remain unsatisfied or disagree with our decision, you can submit a written complaint to us or to U.S. Department of Health and Human Services. We support your rights and will not retaliate if you choose to file a complaint. Our business contact information is: Associates in Plastic & Aesthetic Surgery / Westfield Plastic Surgery Center LLC / 955 S. Springfield Ave, Suite 105 / Springfield, NJ. 07081 / Diane\_at\_NJPlasticSurgeryGroup.com.

Financial Responsibility, Co-Insurance, Co-Pays and Deductibles: You are responsible for costs incurred during the course of your treatment, even if unexpected. An example would be surgery to repair an injury, and a second problem in need of repair was found during the course of surgery. Such costs may include any cost sharing amounts per your insurance plan (copay, deductible and/or coinsurance). We reserve the right to collect cost-sharing amounts (or estimates) in advance of treatment. If your treating physician does not participate with your plan and you elect to seek treatment, this is referred to as out-of-network (OON) care. In such instances, our non-participation status will be discussed with you in advance (see below), including pricing and how your insurance plan determines covered amounts. If you provide incorrect or outdated insurance information and that results in denial / non-payment of a service, you will be responsible for the billed amount. If your insurer denies a treatment as "cosmetic" after-the-fact (after the service is rendered), you will be responsible for the billed amount. If you receive any check or other payment from an insurance company, or third-party payor, for services rendered by "Providers", you will immediately endorse the check and present it to "Providers", along with the explanation of benefits (EOB); Your balance must be paid in full within sixty (60) days or an annual service charge of 16% will apply. At our sole discretion, we may choose to waive or delay implementation of such a fee. We may, at our sole discretion, also choose to waive any balanced owed in excess of your insurance determination, but your cost sharing would still apply. If your insurance company fails to pay within 60 days, we reserve the right to ask you to make payments, partial or in full. If an attorney or collection agency is required to collect payment, the costs of collection (30%) and legal services (actual billed) will be added to your account and will be your financial responsibility.

Digital Photos / Videos: Photos and/or videos (collectively referred to as "images") of the treatment area(s) may be obtained during the course of your treatment and may be used to document care. The images may include your face or other parts of your body, including private areas. While in our office, images of your treatment areas will never be obtained secretly or in a manner where you won't know that they're being obtained. You always retain the right to ask the person taking the photos to refrain or omit certain areas. The digital images shall become the property of "providers" and may be retained by them indefinitely. Many patients find viewing before and after images to be extremely helpful when making their own treatment decision and we support the use of such images to further the interests of public education. "Images" may be used in such capacity in our office or released for the limited purpose of including them in print, visual or electronic media such as in medical journals, textbooks, or at meetings. However, we will always ask for your consent if the images include your face. We may also use them on our website(s), such as in a photo gallery of before and after pictures, and/or for advertising / social media purposes, and for such uses, you will be asked to sign a separate consent.

Out of Network (OON) Treatment: Federal Law (No Surprises Act) and State Law (New Jersey Out-of-network Consumer Protection, Transparency, Cost Containment and Accountability Act) offer protections against surprise medical bills and balance billing. The following information is meant as a summary. A complete copy of these laws was made available to you at the time of your initial visit, is posted by our front desk, and can be found on our website (NJPlasticsurgerygroup.com). The insurance plans with which each physician participates is posted on our web sites. Dr. Zeitels and Dr. Tepper do not participate with the same plans. As of the date of this writing, Dr. Zeitels and Dr. Tepper participate with Medicare. Private Medicare plan participation varies. Both doctors can treat patients under workers compensation (with prior authorization) and NJ Auto ("PIP"). Neither physician participates with any Medicaid plan. Dr. Zeitels participates with some commercial plans but not all. Neither physician participates with Cigna or Aetna. Dr. Tepper does not participate with any other commercial plan. Participation status can change at any, and insurance company rosters may contain inaccuracies, so always verify participation status with us prior to receiving any care. Should you choose to access care from us outside of your network, we are required to advise you that costs may be higher than if you seek care from an in network provider. However, the differences may be surprisingly less than one might think. We believe our fees are fair and reflect the personalized service not often found with participating providers, and we are free of restrictions that insurers may impose on their contracted providers. Prior to treatment, we will discuss the financial arrangement with you, including your anticipated costs. Payment options may include requiring full payment in advance of treatment, or submitting insurance claims after care is rendered. We are not permitted to entice you with up front offers which ignore cost sharing. If you have no out-of-network benefits, or no insurance altogether, we will present you with a fee, usually payable in advance, unless written arrangements are made with you. We will often submit OON insurance claims on your behalf, but this is a courtesy, and we reserve the right to decline. When providing care in advance of payment and then submitting claims on your behalf, we will provide you with our best estimate of your responsibility, but it is limited by how much your plan will divulge about its fee schedule. We will make a good faith effort to explain your coverage, but insurers often limit the information they will release to us. Except in cases of trauma / situations where it is unclear what will be required intraoperatively, we will know the billing (CPT) codes and offer them to you in advance so you can contact your insurer to verify coverage and financial remuneration. We reserve the right to accept of your insurance plan determination in determining your responsible portion and waive balances that. Cost sharing amounts (deductibles, co-insurance, etc.) remain your responsibility. If the insurance company disagrees with / denies a code(s), we will appeal the determination. You agree to participate in, facilitate, and/or expedite any and all requests by us or your insurer in a timely manner. In cases where you do not, we will bill you for those fees. Insurance checks may be mailed to you. Any insurance check(s) mailed to you are not your property, even if made out in your name or the member's name. All checks must be promptly mailed /delivered to our office within 14 days of receipt with the explanation of benefits. Failure to adhere to any of the requirements herein will result in forfeiture of any agreement made waiving excess balances, and such balances (i.e. the full bill) will be your responsibility, along with any legal and/or collection costs.

**Cosmetic Fees:** Cosmetic treatment means your insurance company regards it as not medically necessary. Costs will be discussed in advance of treatment. Besides our fees, we often collect fees for others (hospital, anesthesia, implants) in advance of treatment. We do this solely for your convenience and then send payment to the respective parties. We do not “mark-up” hospital and anesthesia fees. Procedures performed at a hospital or outside surgery center are subject to the financial rules of that facility and their associated anesthesia department. Any disagreement, concern, or billing matter you may have concerning those outside entities must be addressed directly with them. If you prefer to pay them directly, you may do so. Our willingness to collect fees on their behalf should not be construed as anything other than a convenience for you. We are not their business partner, and we bear no responsibilities for their actions. Hospital and anesthesia charges are determined by time. When you are presented with a treatment plan, our quote for those services is based on an estimate of time. If your procedure is completed in less time, you will receive a refund from the facility / anesthesia. If your procedure requires more time than anticipated, you will be billed a fee for the additional time by those entities. Security any refund, or paying any additional fees, is solely your responsibility.

**Complications, Revisions, and Post Operative Care:** For major surgery, we provide routine post operative care for 90 days. After 90 days, we may charge for ongoing treatment. No procedure is ever without risk. While we never want a complication to occur, if one were to occur, you may require additional care, including medication, hospitalization, surgery, testing, and/or care by other physicians / specialists. Any additional treatment, and any associated cost(s), is not included in the price for surgery, and is your financial responsibility. Your health insurance plan may cover certain costs, especially if your procedure was a covered service, but each plan varies, and you should verify ahead of time whether there are any restrictions on coverage for elective and non-elective complications. Insurance plans don’t cover revisions to cosmetic surgery areas and additional costs may be incurred if you require one. Occasionally, a patient may not be fully satisfied with the outcome of a procedure or decide that a little “more” surgery is needed. Patients must understand that surgery is not an exact science. There is no way to guarantee a particular outcome and that also applies to cosmetic surgery and what the area “will look like” afterwards. While we hope every patient is pleased with his/her outcome, dissatisfaction should not be construed as an offer or right for further treatment. For patients who undergo a revision, the costs for revision surgery, including surgeon, hospital, anesthesia and any/all associated care, are extra and not included in the original payment. At our sole discretion and with no implied warranty, guarantee or admission of any kind, we may choose to offer a revision or extend our care at no cost or reduced cost but any associated charges (facility, anesthesia, laboratory, other) remains your responsibility. An executive decision can occasionally be made to refund or eliminate a patient balance as the cost of business and not a reflection on quality or outcome.

**Personal Injury Lawsuits:** If you initiate a personal injury lawsuit against another entity because of the injury for which you (or someone under your care) received care by “providers”, the following stipulations will apply. You will notify us immediately when your lawsuit is filed and provide us with the name and contact information of your attorney. You authorize your attorney to share details of your case with us, including the docket number, county, proximity to a settlement / court case and any anticipated settlement or court judgement. If you were offered a reduction in pricing from our usual and customary rates as listed on the insurance claim submission(s), the full amount of that reduction will be paid to us in the event that you prevail in your legal matter (by settlement or jury verdict) and receive a monetary award. If you have Medicare (or similar private Medicare advantage plan), Medicaid, or other plan with a statutory fee schedule, and a subrogation action shifts responsibility for payment from such a plan to another party that has no statutory fee schedule, this section will also apply and our usual and customary rates (as defined by the lesser of billed amount or Fair Health 90th percentile) will apply. You also direct your lawyer to pay us directly out of the court proceeds prior to your disbursement.

**Cancellations, Penalties, Fees:** Last minute cancellations are disruptive and result in unused time. We reserve the right to impose the following penalties for last minute cancellations: Missed office visits (without notice) will be assessed a fee of \$200. Balances remaining after forty-five days will be subject to sixteen percent interest (annually). If payment of our fees is not made in what we consider to be a timely manner (thirty days) your account may be sent to collection and may be subjected to additional charges and fees associated with such collection. If you pay by credit card, or your insurer pays by credit card, we may impose a three-and-a-half percent surcharge on your account to cover the costs of processing. If you cancel surgery within one week, you forfeit fifty percent of the fee. If you cancel within three days, you will forfeit the entire fee.

**LIST THE NAMES OF PEOPLE WITH WHOM WE CAN SHARE YOUR INFORMATION**

**IF THE PERSON IS NOT LISTED, WE CANNOT DISCUSS ANY OF YOUR CARE WITH THEM.**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

I acknowledge that I have read this ENTIRE packet, that I fully understand and accept all the provisions herein, and that I personally signed this page.

\_\_\_\_\_  
Signature of patient (or authorized rep)

\_\_\_\_\_  
Printed the Name of the Person Signing

\_\_\_\_\_  
Date



## Authorization for Release of Digital Images

Name \_\_\_\_\_ Address \_\_\_\_\_

I consent to the taking of photographs and / or video (herein referred to as "digital images") by Dr. Richard Tepper ("the doctor") and / or staff at Associates in Plastic & Aesthetic Surgery ("APAS"). The digital images may be of my face or parts of my body, in connection with the plastic surgery procedure(s) to be / already performed by Dr. Richard Tepper.

I provide this authorization as a voluntary contribution in the interests of public education. I understand that the digital images shall become the property of Dr. Richard Tepper and APAS, and may be retained by them indefinitely or released for the limited purpose of including them in any print, visual or electronic media, specifically including, but not limited to, medical journals, consumer magazines, textbooks, advertising flyers, internet web sites, social media forums, and mobile apps, for the purpose of informing the medical profession or the general public about plastic surgery procedures and methods. Some of these uses could be considered "promotional" or advertisements. Entities to whom the digital images may be released include, but are not limited to, The American Society of Plastic Surgeons (ASPS), American Society for Aesthetic Plastic Surgery, other professional organizations, current or future companies or people associated with web page design, web hosting, advertising or marketing for Dr. Richard Tepper and/or APAS. I understand that my face will only be visible if that is the area of treatment and that I will not be identified by name in any publication. However, I recognize that in some instances, the digital images may portray features that will still make my identity recognizable.

I understand that my signature below is an acknowledgement that I am aware that I may be / have been photographed and that I may refuse to authorize the release of such digital images in part, or in full, per the above description, and that my refusal will not affect the health care I receive, or will receive, from the doctor. I understand that I have the right to revoke this authorization in writing at any time, but if I do so, it won't have any effect on any actions taken prior to my revocation. I understand that the information disclosed, or some portion thereof, may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). I further understand that because some of the organizations or companies enlisted by Dr. Tepper or APAS to facilitate the above use of the digital images may not be receiving the information in the capacity of a health care provider or health plan covered by HIPAA, the information described above may no longer be protected by HIPAA. The following are my limitations for release: \_\_\_\_\_,

I release and discharge Dr. Richard Tepper and APAS, and all parties acting under their license and/or authority, from all rights that I may have in the digital images and from any claim that I may have relating to such use in publication (print, educational, web-based, etc.), including any claim for payment in connection with distribution or publication of the digital images.

I certify that I have read the above Authorization and Release and fully understand its terms.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

I have read the above Authorization and Release. I am the parent, guardian, or conservator of \_\_\_\_\_ a minor. I am authorized to sign this authorization on his/her behalf, and I give this authorization as a voluntary contribution in the interest of public education.

**ASSIGNMENT OF BENEFITS/DESIGNATED AUTHORIZED REPRESENTATIVE/LIMITED SPECIAL POWER OF ATTORNEY**

**Assignment of Benefits:** I hereby assign and convey to the fullest extent permitted by law any and all benefit and non-benefit rights (including the right to any penalties or equitable relief) under my health insurance policy or benefit plan to Associates in Plastic & Aesthetic Surgery, Jerrold Zeitels MD, Richard Tepper, MD, Westfield Plastic Surgery Center LLC ( "Providers") with respect to any and all medical/facility services provided by "Providers" to me for all dates of service, including without limitation, the right of one or more "Providers", or their attorney ( or their representatives) to (i) execute, in my name and on my behalf, any form, document or instrument required under any applicable insurance policy or benefit plan to further evidence my intent as set forth herein and to avoid any delay in pursuing rights under applicable Federal and State laws, rules, regulations or requirements (collectively, "Laws"), (ii) pursue penalties for and exclusively on behalf of "Providers" against any insurance policy or benefit plan for failure of the plan administrator (or other fiduciary) to timely produce or respond to requests (including appeals) for all information relating to any plan documents as required by any applicable Laws, (iii) to assert claims and initiate legal action for breach of fiduciary duty against and person or entity, and (iv) to endorse for me any checks made payable to me for benefits and claims collected toward my account. In the event the insurance carrier responsible for making medical payments to "Providers" for medical services rendered to me does not accept my assignment of benefit rights, or my assignment is challenged or deemed invalid, I execute this limited/ special power of attorney and appoint and authorize "Providers" and their attorney(s) (or other representative(s)) as my agent and attorney, in fact, to assert any and all of my benefit and non-benefit rights for and on my behalf, including, without limitation, to bring any appeal, pre-litigation demand, demand for payment, arbitration, lawsuit, independent dispute resolution or administrative proceeding, for and on my behalf, in my name against any person and/or entity involved in the determination and payment of benefits under any insurance policy or benefit plan. I agree that any recovery shall be applied to payment due my provider and attorney fees and costs. To this end, Provider has exclusive settlement authority.

**Designated Authorized Representative:** I hereby appoint as a Designated Authorized Representative each of my "Providers" and each of their respective assistants (medical and administrative), billing staff, lawyers or any other person or business that provides healthcare activity services as a "business associate" under the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), and their respective designees (collectively referred to herein as an "Authorized Representative"). This authorization is intended to comply with all requirements of the Employment Retirement Income Security Act of 1974, as amended ("ERISA") and any applicable State law. Each Authorized Representative is granted the same rights which I have as a member or beneficiary under my insurance policy or benefit plan, including without limitation:

1. The to file claims for benefits on my behalf and directly receive payment for benefits and non-benefits under my insurance policy or benefit plan, including the right to penalties, interest and attorney fees.
2. The right to communicate with insurers, plan fiduciaries, employers and plan and claim administrators relative to all my benefit information and protected health information ("PHI" as further defined under HIPAA) and to share and exchange such information with a "covered person" or "business associate" as those terms are defined under HIPAA.
3. The right to send and receive follow-up information and obtain all documentation that ERISA or any State law requires to be provided to me, including, without limitation, plan documents, explanation of benefits, adverse benefit determinations, all relevant documents involving my claim, identity of all persons involved in determining my claim and all documents relied upon in making any determination as to the payment of any amount under the applicable plan documents.
4. The right to file any internal or external member appeal for payment of benefits under any applicable insurance policy or benefit plan.
5. The right of my Authorized Representative to pursue any rights, claim or cause of action through pre-litigation demands, demands for payment, arbitration, independent dispute resolution or administrative proceeding, litigation or otherwise under any Federal or State law with respect to payment for services provided by a Provider to me, including penalties, interest and attorney fees.

**Release of Private Health Information:** It is specifically intended that any Provider or Authorized Representative is authorized and directed to provide and release my PHI for purposes of exercising all rights and benefits set forth in this Assignment of Benefits/Designated Authorized Representative authorization to any "covered person" or "business associate", including third-party payors, internal and external utilization review organizations, regulatory review entities and other organizations and/or companies that may/will assist with claims processing/reimbursement. I also direct any plan or claim administrator or plan sponsor to share all PHI with any Provider or Authorized Representative and not to inhibit the exercise of rights under my insurance policy or benefit plan by requiring any further authorization signed by me. This form does not constitute legal advice and covers only Federal, not State, law. This Assignment of Benefits/Designated Authorized Representative authorization/ Limited Special Power of Attorney shall remain in full force and effect for all current and future dates of service, until such time all rights have been exercised under applicable Federal and State law as determined by Providers. I may revoke or withdraw this authority upon written notice to the Providers. In the event of any revocation, I will be responsible for payment of all outstanding amounts then due to the Providers.

\_\_\_\_\_  
Signature of patient (or authorized person)

\_\_\_\_\_  
Print name

\_\_\_\_\_  
Date