I have read all of the information on this sheet and have completed the responses. I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or any changes regarding the above responses.

ASSIGNMENT OF HEALTH PLAN BENEFITS AND
RIGHTS AND ERISA REPRESENTATIVE DESIGNATION

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay Atlanta Center for ENT (ENT and Facial Plastic Surgery, LLC) the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided.

I hereby authorize payment of any health insurance or medical plan benefits directly to Atlanta Center for ENT (ENT and Facial Plastic Surgery, LLC) for medical services rendered and for any supplies, tests, or medications provided.

I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same.

I hereby assign directly to Atlanta Center for ENT (ENT and Facial Plastic Surgery, LLC) all rights to payment and benefits and all legal and other health plan, ERISA plan, or insurance contract rights that I (or my child, spouse, or minor dependent) may have under my / our applicable health plan(s) or health insurance policy(ies). This assignment includes, but is not limited to, a designation that Atlanta Center for ENT (ENT and Facial Plastic Surgery, LLC) can act on my / our behalf, as our representative or ERISA representative, as to any initial claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals to obtain benefits and / or payments that are due to Atlanta Center for ENT (ENT and Facial Plastic Surgery, LLC) as a result of services rendered by Atlanta Center for ENT (ENT and Facial Plastic Surgery, LLC), and to pursue any and all remedies to which I / we may be entitled, including the use of legal action against the health plan or insurer. This assignment and designation remains in effect unless revoked in writing, and a photocopy is to be considered as valid and enforceable as the original.

Patient signature (or Guardian):_____ Date:_____