Financial Responsibility

I have requested professional services from Signature Care Emergency Center (the "Provider") on behalf of myself and/or my dependents, and understand that by making this request that I am responsible for all charges incurred during the course of said services. I understand that all fees for said services are due and payable on the date those services are rendered, and I agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement unless other arrangements have been made in advance.

Assignment of Benefits

I hereby assign all applicable health insurance benefits to which I and/or my dependents are entitled to the Provider. I certify that the health insurance information that I provided to the Provider is accurate as of the date set forth below and that I am responsible for keeping it updated with the Provider. I hereby authorize the Provider to submit claims, on my behalf and/or my dependents' behalf, to the benefit plan (or its administrator) listed on the current insurance card that I provided in good faith to the Provider. I authorize the Provider or any holder of medical information about me or the patient listed below to release to my health insurance plan such information needed to determine these benefits or the benefits payable for related services. I hereby instruct my benefit plan (or its administrator) to pay the Provider directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to the Provider, I hereby instruct and direct my benefit plan (or its administrator) to provide documentation of such non-assignment to myself and the Provider upon request. Upon proof of such non-assignment, I hereby instruct my benefit plan (or its administrator) to make out the check to me and mail it directly to the Provider. If my health insurance plan will not direct payments to the Provider, I agree to forward to the Provider all health insurance payments which I receive for the services rendered by the Provider and its health care providers.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for the professional services that I received from the Provider are paid in full. I understand that I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment. I fully understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately. I further agree that if permissible by law, I will reimburse the Provider for all costs, expenses and attorney's fees that may be incurred by the Provider or a third party contracted provider to collect those charges.

Power of Attorney

I hereby irrevocably designate, authorize and appoint the Provider as my true and lawful attorney-in-fact. This power of attorney is hereby provided for the purpose of receiving all payments due under my policy/medical care plan on account of the medical services and care rendered or to be rendered. In the event that my health insurance plan or any other responsible party does not accept my assignment or my assignment is deemed invalid, I execute this power of attorney and appoint and authorize the Provider to file suit and/or participate in arbitration in order to collect payment for my medical services. I specifically authorize the Provider to file directly against the carrier in my name or in the Provider's name as a medical provider rendering services to me. This power of attorney shall automatically terminate as soon as the Provider has received payment in full.

Authorization to Release Information

I hereby authorize the Provider or appointed business associates by the Provider to be my personal representative which allows them to: (1) release any information necessary to my health benefit plan (or its administrator), insurance company, adjuster, governmental agency or attorney involved in this regarding my illness and treatments; (2) process insurance claims generated in the course of examination and/or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

ERISA Authorization

I hereby designate, authorize, and convey to the Provider to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan, as my Authorized Representative: (1) the right and ability to act on my behalf in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act on my behalf to pursue such claim right, or cause of action in connection with said insurance policy and/or benefit plan (including, but not limited to, the right to act on my behalf in respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. Section 2560.5031(b)(4)) with respect to any healthcare expense incurred as a result of the services I received from the Provider and, to the extent permissible under law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines.

As my Authorized Representative under ERISA, the Provider shall have the right to act on my behalf, including but not limited to, submitting any and all appeals when my insurance company denies me benefits to which I am entitled, submitting any and all requests for benefit information from my insurance company, and initiating formal complaints to any state or federal agency that has jurisdiction over my insurer and/or benefits.

This Assignment of Benefits Form applies and extends to subsequent visits and appointments at Signature Care Emergency Center. A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

I certify that I have read and that I understand the above statements, that all of my questions have been answered to my satisfaction, and that I agree with each statement.

Signature of the Insured or Parent/Guardian: _____

Printed Name of Person Signing Below: _____

Relationship to the Insured: _____ Date _____