Assignment of Benefits/Erisa Authorized Representative Form

Surgeon Surgery Center & Cimarron Surgery Center

Financial Responsibility

I have requested professional services from Surgeon Surgery Center & Cimarron Surgery Center, ("Provider") on behalf of myself and/or my dependents, and understand that by making this request, 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 services are rendered and 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 Insurance Benefits

I hereby assign all applicable health insurance benefits to which I and/or my dependents are entitled to Provider. I certify that the health insurance information that I provided to Provider is accurate as of the date set forth below and that I am responsible for keeping it updated.

I hereby authorize Provider to submit claims, on my and/or my dependent's behalf, to the benefit plan (or its administrator) listed on the current insurance card I provided to Provider, in good faith. I also hereby instruct by benefit plan (or its administrator) to pay Provider directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to Provider, I hereby instruct and direct my benefit plan (or its administrator) to provide documentation stating such non-assignment to myself and Provider upon request. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make our the check to me and mail it directly to Provider.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.

Authorization to Release Information

I hereby authorize Provider to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examiniation or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. I understand that any information disclosed pursuant to this authorization may be disclosed by the recipient pursuant to my providers Notice of Privacy disclosure and may not be protected by the federal privacy regulation. I understand that I have a right to revoke this authorization at any time by providing written notice to my Provider and my health benefit plan (or administrator) via electronic mail, U.S. mail or facsimile. I further understand that there are no exceptions to my rights to revoke this authorization. Therefore, this authorization will remain in force and effect for claims with date of service within one year of signature date, or until revoked by me in writing, or until my healthcare claims are adjudicated to my provider's satisfaction.

ERISA Authorization and Limited Power of Attorney

I hereby designate, authorize, and convey to Jim Sholeff and/or Claimocity, LLC, Provider's Third-Party Billing Service for the claims assigned hereunder, to full extent permissible under law and under any applicable insurance policy and/or employee health care benefit

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

_____	_____
Patient	Date
_____	_____
Policyholder/Insured	Date
_____	_____
Social Security Number	Date
_____	_____
Address	Telephone Number