Assignment And Designation Of Beneficiary As To Health Plan Benefits And Rights, Together With Erisa Representative Designation

I understand based on my completed Insurance Benefits Verification Worksheet, Creative Health Solutions LLC ("Creative") will process my claims with my insurer. To enable Creative to do so I am providing the following authorization, assignment, and agreement.

I hereby authorize and designate that payment of any health insurance or medical plan benefits be made directly to Creative, as a beneficiary under the applicable health insurance or medical plan, for medical services rendered and for any supplies or medications provided.

I hereby authorize the release of information as to my health status, conditions, symptoms or treatment 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 Creative 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 Creative 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, administrator, or insurer, to file and pursue appeals to obtain benefits and / or payments that are due to Creative as a result of services rendered by Creative, and to pursue any and all remedies to which I / we may be entitled, including the use of legal action against the health plan, its administrator(s), and/or insurer(s). 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.

I understand and agree that (regardless of whatever health insurance or medical benefits I have) I am ultimately responsible to pay Creative the balance due on my account for any testing or professional services rendered and for any supplies. Furthermore, I am responsible for keeping track of session limits, deductibles, co-pays, co-insurance, out of pocket maximums, and so on, and must inform Creative of any changes in my policy and/or change of insurers.

Patient's Name: _____ (please print)

Patient's Signature: _____

(If patient is a minor, signature and printed name of parent/guardian)

Health Plan / Insurance Co. Name: _____

Dated: _____

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