ASSIGNMENT OF BENEFITS AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

In consideration for health care services provided to me by [Insert Entity Name], ("As You Are"), I irrevocably assign, transfer and convey to As You Are all rights and benefits payable under any health plan to which I am entitled benefits ("Health Plan") for services provided to me by As You Are. Further, I designate As You Are as my authorized representative to pursue any benefits to which I am entitled. By this assignment and designation, I authorize payment to be made directly to As You Are.

I further authorize and irrevocably assign to As You Are the following rights while retaining my right to file a separate member grievance:

a. To communicate with my Health Plan, to request any adjustment to my Health Plan's reimbursement of services provided to me, and to file any and all necessary claims, demands, or appeals with my Health Plan arising from a denied, underpaid, or misclassified claim.

b. To demand and receive the production of or access to any documents and information, including but not limited to copies of Health Plan documents, coverage policies, guidelines and any other materials affecting the coverage and reimbursement of any services provided to me, from any entity or person to the fullest extent of my rights to do so under applicable laws;

c. To bring legal action, if needed, in any forum against my Health Plan under applicable laws, including, but not limited to the Employee Retirement Income Security Act of 1974 ("ERISA") and/or the Federal Employee Health Benefit Act ("FEHBA");

   i. To recover benefits under the terms of my Health Plan, to enforce my rights under the terms of my Health Plan, or to clarify my rights to future benefits under the terms of my Health Plan;

   ii. To enjoin any act or practice which violates any provisions of ERISA, the terms of my Health Plan, or applicable law and/or to obtain other appropriate equitable relief to redress such violations or to enforce any provisions of ERISA, the terms of my Health Plan, and/or applicable law; and

   iii. To recover the costs of pursuing such action, including reasonable attorney fees, as permitted.

The foregoing designation and assignment of benefits and rights are without limitation and without reservation of any part or aspect thereof.

I understand that this authorization and designation does not relieve me of financial responsibility for charges incurred by me or anyone on my behalf. If my Health Plan sends to me the payments for services provided by As You Are, I am to immediately send those payments to As You Are. If I fail to do so, I will be responsible for those amounts, in full, as well as any associated cost-share, deductibles, co-pay and/or co-insurance. In the event I overpay As You Are on a private pay account, I authorize As You Are to apply such overpayment to satisfy any outstanding charges I owe for services received by an As You Are facility. This authorization does not include Health Plan payments made on my behalf and does not include accounts eligible for financial assistance.

Patient Name: _____ Date of Birth:_____

Signature (patient or guardian): _____ Date: _____

If Guardian, printed name:_____