Legal Assignment Of Benefits And Designation Of Authorized Representative

I, (Patient's Name)_____, am the insured, and have health insurance benefits through (Insurance Company) _____, that are provided to me by the following named employer (Name of Employer) _____, that is engaged in commerce, as defined in 29 USC 18§1003(a). I do hereby designate DR. J. BRIAN BOYD, M.D. ("Dr. J. Brian Boyd" or "Provider") and Provider's business associate _____ to be my authorized representatives (together referred herein to as "Authorized Representatives") as defined in Federal Regulation 29 CFR 2560-503-1, to fully act on my behalf to submit my claim(s) for healthcare benefit payments, to obtain any and all information from my health insurance company (Name of Insurance Company) _____, that will be used in an appeal of my adverse benefit determination, as defined in 29 CFR 2560-503-1, and to represent me in a Federal Court of Law, to appeal any and all adverse benefit determinations and any and all actions to ensure that my employer provided health benefit payments are correctly paid.

My health insurance company is to provide Authorized Representatives with any and all requests for the discovery of any and all documents used by (Name of Insurance Company) _____, to deny my health benefit payment when not paid in full. If any outside policies or consultants were used to perform the adverse benefit determination, (Name of Insurance Company) _____, is directed to provide my Authorized Representatives with a legible copy of said policy, the name and specialty of the person who performed the adverse benefit determination, the name and credentials of any consultants, and any and all documents provided by said consultant. My Authorized Representatives are authorized to file grievances with any and all applicable State or Federal regulatory agencies and to represent me in any legal action in a Federal Court of Law. Copies of this authorization are to be treated as if they are the original document.

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage hereby assign and convey directly to provider all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such medical facility and appoint as my designated Authorized Representatives, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from Dr. J. Brian Boyd, M.D. , regardless of Dr. Boyd's managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize Dr. Boyd to release all medical information necessary to process my claims under HIPAA. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to my Authorized Representatives any and all plan documents, insurance policy and/or settlement information upon written request from my Authorized Representatives in order to claim such medical benefits, reimbursement or any applicable remedies.

I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. I hereby convey to my Authorized Representatives, to the full extent permissible under the law and under any applicable employee group health plan(s), insurance policies or liability claim, any claim, chose in action, or other right I may have to such group health plans, health insurance issuers or tortfeasor insurer(s) under any applicable insurance policies, employee benefits plan(s) or public policies with respect to medical expenses incurred as a result of the medical services I received from Dr. Boyd, and to the full extent permissible under the law to claim or lien such medical benefits, settlement, insurance reimbursement and any applicable remedies, including, but are not limited to, (1) obtaining information about the claim to the same extent as the assignor; (2) submitting evidence; (3) making statements about facts or law; (4) making any request, or giving, or receiving any notice about appeal proceedings; and (5) any administrative and judicial actions by Dr. Boyd to pursue such claim, chose in action or right against any liable party or employee group health plan(s), including, if necessary, bring suit by Dr. Boyd against any such liable party or employee group health plan in my name with derivative standing but at such provider(s) expenses. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal or state laws. A photocopy of this assignment is to be considered as valid as the original.
I have read and fully understand this agreement.

_____ _____

Signature of Insured Date