PERFORMANCE SURGERY CENTER
1084 MAIN AVE., 2ND FL. ♦ Phone: (973) 574-3520 ♦ Fax: (973) 473-2630

Authorization for Direct Payment / Power of Attorney Designation / Release of Documents
Designation of Authorized Representative / Assignment Agreement

WHEREFORE, I am a participant, beneficiary, subscriber, or enrollee of a health insurance policy or plan ("my Insurance", which includes all types and sources of insurance coverage applicable to my specific situation, including but not limited to Medicare, Medicare Advantage, Medicare Supplement, TRICARE, Medicaid, worker's compensation, individually-purchased insurance, and/or coverage provided by my employer, whether through a self-funded or fully-insured health care benefit plan, including COBRA coverage);

WHEREFORE, my Insurance is provided by my employer _____ **[specify employer, if applicable]**;

WHEREFORE, my Insurance is administered, issued, and/or insured by _____ **[specify insurance company]** and, as applicable, other fiduciaries;

WHEREFORE, I have received and/or am seeking health care services from Performance Surgery Center (hereinafter, the "Provider"), which I believe to be covered services under my Insurance, and I may seek additional services from Provider in the future;

WHEREFORE, it is my intention to have any benefits owed to me by my Insurance paid directly to Provider, and to give to Provider the right to bring -- on my behalf -- any and all legal or equitable claims that I have against my Insurance and/or its fiduciaries relating in any way to benefits that are owed to me or may be owed to me in the future with respect to such services; and

WHEREFORE, it is also my intention, as an alternative basis for having benefits owed to me by my Insurance paid directly to Provider and giving Provider the right to bring any and all legal or equitable claims that I have against my Insurance and/or its fiduciaries relating in any way to benefits that are owed to me or may be owed to me in the future with respect to such services, to transfer, give, and assign my benefits under my Insurance to Provider,

NOW, THEREFORE:

A. Patient Acknowledgement of Liability

I understand and acknowledge that I am liable for the full charges, as permitted by law, for the health care services that I receive from Provider and agree to pay all such charges that are not paid by my Insurance. In exchange for Provider providing services to me now and in the future without requiring payment of these charges up front, and for Provider having agreed to submit claims for benefits to my Insurance, and because Provider is in a better position to file such claims than I am, I hereby execute the following authorization, designations, and/or assignment.

B. Authorization to Receive My Benefit Payments

I authorize Provider to submit claims for Insurance benefits (each, a "Benefit Claim") directly to my Insurance and/or its fiduciaries and I authorize and direct my Insurance and/or its fiduciaries to pay such benefits directly to Provider, and I hereby designate Provider as the person entitled to such benefits, pursuant to ERISA, 29 U.S.C. § 1002(8) where applicable, including all benefits owed now or in the future by my Insurance for covered services provided by Provider.

C. Power of Attorney Designation

To the extent any dispute arises between Provider and my Insurance and/or its fiduciaries relating to a Benefit Claim or the manner in which similar claims will be treated by my Insurance and/or its fiduciaries now or in the future, it is my intention that my Insurance and/or its fiduciaries give Provider on my behalf any and all rights to which I would otherwise be entitled, and I therefore appoint Provider as my true and lawful attorney-in-fact for the purpose of exercising the following powers on my behalf:

1. To do all acts necessary for the purpose of pursuing administrative appeals;
2. To do all acts necessary for the purpose of investigating, filing, pursuing, and resolving litigation on my behalf (including but not limited to selecting and retaining legal counsel) of any and all legal and equitable claims that I could bring against my Insurance and/or its fiduciaries. Such legal and equitable claims shall include, but not be

limited to, any and all claims (including breach of fiduciary duty claims) that I could bring pursuant to ERISA, 29 U.S.C. § § 1132(a)(1), (a)(2) or (a)(3), or other provisions of ERISA that grant me a cause of action, where applicable; other federal or state statutes; or the common law, and shall include class claims in which Provider serves as a class representative (hereinafter, collectively, "Causes of Action"). If Provider brings such an action, I agree to be bound by a final determination of such action rendered by a court or regulatory proceeding.

3. To sign on my behalf settlement agreements, releases, or other documents relating to the settlement of the Causes of Action. I hereby agree to be bound by any settlement, compromise or release reached by Provider on my behalf and that any document executed in connection with any such settlement, compromise or release by Provider on my behalf shall be binding on me.
4. To claim on my behalf any benefits, reimbursements, damages, surcharges, or any other applicable remedy, including fines or injunctive relief, to which I am entitled in connection with the Causes of Action.
5. I hereby confirm and ratify all actions taken by my attorney-in-fact pursuant to the authority granted herein.

D. Designation of Authorized Representative

To the extent the Power of Attorney designation described in Section C above is deemed ineffective for any reason, I hereby designate Provider as my Authorized Representative as provided under ERISA, 29 C.F.R. § 2560.5031(b)(4), where applicable, for purposes of exercising the powers described in Section C or authorized under law, whichever are greater.

E. Assignment of Benefits and Legal Rights

To the extent or in the event that any power(s) and/or rights conveyed by Sections B, C, or D are deemed ineffective or limited for any reason or in any way, I hereby transfer, give, assign, and otherwise convey to Provider, for good and valuable consideration, the receipt and sufficiency of which are hereby expressly acknowledged: (a) all of my right, title, and interest in benefits under my Insurance for the covered services I received, and (b) all legal and equitable rights that I have as a participant, beneficiary, subscriber or enrollee, including, but not limited to, all rights to: (i) submit a Benefit Claim directly to my Insurance and/or its fiduciaries; (ii) receive all benefits otherwise due me under my Insurance for covered services; and (iii) bring any Cause of Action against my Insurance or any of its fiduciaries to obtain such benefits, to enforce the fiduciary duties owed to me by my Insurance and/or its fiduciaries, or to obtain any other appropriate legal or equitable relief available under the Cause of Action.

F. Acknowledgements

By signing this form, I understand that Provider is not assuming any obligation or duty to assert the rights conveyed herein, and I agree to release any claim I might have relating to Provider's exercise of such rights or the decision not to exercise such rights.

If Provider initiates a lawsuit against me to collect any unpaid balance owed for services provided to me, all the rights and powers conveyed herein shall be rescinded and I retain any claims or defenses I otherwise may have against Provider.

A photocopy of this Agreement shall be as effective and valid as the original.

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

Patient Name (Print)	Patient's Insurance Identification Number
Patient (or Legal Guardian's) Signature	Date
Policyholder/Insured (If **Not** Patient)	Policyholder/Insured Insurance Id Number
Policyholder/Insured (If **Not** Patient) Signature	Date