

**LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS**

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Integrated Health, S.C. all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I clearly understand and agree that all of the services rendered to me are charged directly to me and that I am personally responsible for all payments. I understand that if I suspend or terminate my care, any fees for professional services rendered to me will be immediately due and payable. I further understand that I am responsible for any attorneys' fees, court costs, filing fees, subpoena fees, and travel expenses associated with the collection of any unpaid debt to Integrated Health, S.C. I understand that interest will accrue at 1.5% monthly, every 30 days for any and all outstanding balances. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic 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 the above named doctor and clinic to the full extent permissible under law and under any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from named doctor and clinic and to the extent permissible under the law to claim such medical benefits, reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor against such insurers and/or employee health care plan in my name.

I further authorize the staff to perform such services as deemed necessary by the physician to diagnose and treat my condition(s). I understand that I am fully responsible for all charges which may include legal fees, collection fees or other expenses incurred by the provider in collecting my account.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

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Signature of Insured (Guardian)

\_\_\_\_\_  
Date