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ASSIGNMENT OF BENEFITS

I, ______________________________ (patient name) understand and agree that I am responsible for the total charges for services rendered, and that Elite Dermatology may bill my insurance company, if any, as a courtesy.

In consideration of services rendered, I hereby irrevocably assign and transfer to Elite Dermatology for myself and my "dependent," if applicable, all rights, title and interest in the benefits payable for services rendered which are provided in any insurance policy(ies) or group health plans under which we are insured or provided coverage for health benefits for the purpose of granting Elite Dermatology an independent right of recovered based upon my rights under such policies or group health plans. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

I hereby appoint Elite Dermatology as my duly authorized representative(s) and attorney-in-fact to act on our behalf, to seek payment of my benefit claims and pursue my rights to medical coverage and the benefits that flow from such coverage, to file appeals related to such claims and to request documents relevant to such claims and direct and authorize any payor to communicate with such authorized representative(s) regarding all of our benefit claims with respect to Elite Dermatology.

I hereby direct payment under any such plans, policies and programs to be made directly to Elite Dermatology for services and items provided to me and my dependents. In the event payment is made to me contrary to this agreement, I will promptly turn over payment in full to Elite Dermatology.

I further assign to Elite Dermatology and its agents all rights, claims or causes of action I may have to request and obtain documents from any health plan and its affiliated insurers, employers and third party administrators that relate to coverage or non-coverage of benefits or payment of charges for medical rendered, including, without limitation, my certificate of coverage, policy and/or summary plan description; any master policy or governing plan document that differs from the certificate of coverage, policy and/or summary plan description; copies of any policies or procedures used to decide my claim; and a complete copy of any other claims adjudication information so that Elite Dermatology can determine if a full and fair review of my claim took place.

I assign to Elite Dermatology and its agents my rights and any claims or causes of action I may have to collect any penalties for my health plan's failure to timely produce this required information.

If my account becomes delinquent and it is referred to an attorney or collection agency, I agree that I will pay all charges, interest from the due date at eighteen percent (18%) or the maximum rate allowable by law, reasonable attorney fees, costs and collection expenses.

Patient's Name (Printed):___________________________

Representative's Name (if Patient is a dependent):_____________________________

Signature*:_____________________________________

Date:___________________

*To be signed by Patient or, if Patient is a dependent, Patient's Representative.

Revised 02/26/2023