ASSIGNMENT OF BENEFITS / ERISA AUTHORIZED REPRESENTATIVE FORM

Assignment of Insurance Benefits – Appointment as Legal Authorized Representative

I hereby assign all applicable health insurance benefits and all rights and obligations that I and my dependents have under my health plan to the Provider and Law Firm (if applicable) (hereinafter, "My Authorized Representatives") and I appoint them as my authorized representative with the power to:

- ✓ File medical claims with the health plan
- ✓ File appeals and grievances with the health plan
- ✓ Institute and necessary litigation and/or complaints against my health plan naming me as plaintiff in such lawsuits and actions if necessary
- ✓ Discuss or divulge any of my personal health information or that of my dependents with any third party including the health plan

I certify that the health insurance information that I provided to Provider is accurate as of the date set forth below and that I am responsible for keeping it updated.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.

Authorization to Release Information

I hereby authorize My Authorized Representatives to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

ERISA Authorization

I hereby designate, authorize, and convey to My Authorized Representatives to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (1) the right and ability to act as my Authorized Representative in connection with any claim, right, or cause of action including litigation against my health plan (even to name me as a plaintiff in such action) that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act as my Authorized Representative to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including, but not limited to, the right and ability to act as my Authorized Representative with respect to a benefit plan governed by the provisions of ERISA as provided in 29 *C.F.R.* §2560.5031(b)(4) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines. I authorize communication with the Provider and his authorized representatives by email and my email address is _____@_____. I understand I can revoke this authorization in writing at any time

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

_____ _____

Patient Date

About the Author Thomas Force is a nationally recognized as an expert in revenue collection techniques, managed care contracting and appeal strategies. He is a state and federally licensed attorney in New Jersey and New York, Mr. Force has over 21 years of experience in the healthcare and insurance industries. He is the founder of The Patriot Group a full service revenue recovery company that provides billing, collections, and follow-up services as well as assistance with managed care appeals, managed care contracting, credentialing and compliance.

`Have you ever been exposed to Hepatitis? Y N When _____
HIV Virus? Y N When _____
AIDS? Y N When _____

MEDICATIONS: **NAME AND DOSE**

"Sinus" medications	Never ____	Occ ____	Freq. ____	_____
Nose sprays	Never ____	Occ ____	Freq. ____	_____
Tranquillizers	Never ____	Occ ____	Freq. ____	_____
Sleeping pills	Never ____	Occ ____	Freq. ____	_____
Aspirin (not Tylenol)	Never ____	Occ ____	Freq. ____	_____
Cortisone	Never ____	Occ ____	Freq. ____	_____
Thyroid	Never ____	Occ ____	Freq. ____	_____

Have you ever taken Insulin or tablets for diabetes? Y N

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING: _____

_____

ALLERGIES:

Are you allergic to:

Sulfa	Y N	
Penicillin	Y N	
Aspirin	Y N	
Codeine	Y N	
Morphine	Y N	
Antibiotics	Y N	Please specify name of antibiotic you are allergic to:

_____

Please list any other drug allergies: _____
Please list any other allergies such as hay fever, etc.: _____
Have you ever had allergy testing? Y N If yes, when? _____
Have you ever taken allergy shots? Y N If yes, when? _____

FAMILY HISTORY:

Father's age _____ If deceased, cause of death: _____
Mother's age _____ If deceased, cause of death: _____

Do any of your blood relatives have:
Diabetes? Y N Who? _____
Bleeding Disorder? Y N Who? _____
Tuberculosis? Y N Who? _____
Cancer? Y N Who? _____
Inherited Abnormalities? Y N
If yes, please list the abnormality: _____

_____

How many children do you have? _____ N/A
Please list all ages:

_____

NAME: _____ BIRTH DATE: _____ TODAY'S DATE: _____

WEIGHT: _____ HEIGHT: _____ DATE OF LAST PHYSICAL EXAMINATION: _____

IMPORTANT: PLEASE LIST REASONS FOR TODAY'S VISIT: _____

_____

NASAL PROBLEMS:

Do you have a stuffy nose? Y N OCC

Are you a mouth breather? Y N OCC

Do you have any nasal discharge? Y N OCC

Is it clear? Y N OCC

Off color (yellow)? Y N OCC

EAR PROBLEMS:

Does your hearing seem normal? Y N

If not, which is your best ear? R L

Do you have ringing or noises

in your ears? Y N

Is it worse on one side? R L

Are you dizzy? Y N

THROAT PROBLEMS:

Hoarseness: Y N

Duration: _____

Trouble swallowing: Y N

Duration: _____

Foreign Body Sensation: Y N

Duration: _____

SLEEP PATTERN:

Do you sleep well? Y N

Do you snore? Y N

Badly? Y N

Appetite: Good __ Fair __ Poor __

Weight: Stable __ Gain __ Loss __

Salt and salty foods: Light __ Moderate _

Heavy __

Do you have problems with chronic headaches? Y N

Have you ever had a problem with a drug habit? Y N

Alcoholic Beverage Consumption: Never ___ Rarely ___ Moderate ___ Heavy ___

Do you or have you ever smoked? Y N How much? _____

What x-rays, if any, have you had in the last two years? _____

Have you ever had any serious injury? _____

Have you ever been hospitalized for anything other than surgery? _____

SURGERY:

Have you ever had a: Tonsillectomy? Y N Date _____

Appendectomy? Y N Date _____

D&C? N/A Y N Date _____

Hysterectomy? N/A Y N Date _____

Ovarian Surgery? N/A Y N Date _____

Tubal Ligation? N/A Y N Date _____

Please list any other surgeries you may have had: _____

_____

Have you ever had, or do you now have:

Eye problems? Y N Describe _____

Heart trouble? Y N Describe _____

Liver trouble? Y N Describe _____

Stomach trouble? Y N Describe _____

Lung trouble? Y N Describe _____

Prostate trouble? Y N Describe _____

Kidney/Bladder trouble? Y N Describe _____

Nervous system? Y N Describe _____

Unexplained weight loss/gain? Y N Describe _____

Rashes/skin trouble? Y N Describe _____

Depression/Psychiatric trouble? Y N Describe _____

Easy bleeding/bruising? Y N Describe _____

Have you ever been exposed to Hepatitis? Y N When _____

HIV Virus? Y N When _____

AIDS? Y N When _____

MEDICATIONS: NAME AND DOSE

"Sinus" medications Never ____ Occ ____ Freq. ____ _____

Nose sprays	Never ____ Occ ____ Freq. ____	_____
Tranquillizers	Never ____ Occ ____ Freq. ____	_____
Sleeping pills	Never ____ Occ ____ Freq. ____	_____
Aspirin (not Tylenol)	Never ____ Occ ____ Freq. ____	_____
Cortisone	Never ____ Occ ____ Freq. ____	_____
Thyroid	Never ____ Occ ____ Freq. ____	_____

Have you ever taken Insulin or tablets for diabetes? Y N

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING: _____

_____

ALLERGIES:

Are you allergic to:

Sulfa	Y N	
Penicillin	Y N	
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Codeine	Y N	
Morphine	Y N	
Antibiotics	Y N	Please specify name of antibiotic you are allergic to:

_____

Please list any other drug allergies: _____

Please list any other allergies such as hay fever, etc.: _____

Have you ever had allergy testing? Y N If yes, when? _____

Have you ever taken allergy shots? Y N If yes, when? _____

FAMILY HISTORY:

Father's age _____ If deceased, cause of death: _____

Mother's age _____ If deceased, cause of death: _____

Do any of your blood relatives have: Diabetes? Y N Who? _____
Bleeding Disorder? Y N Who? _____

Tuberculosis? Y N Who? _____

Cancer? Y N Who? _____

Inherited Abnormalities? Y N

If yes, please list the abnormality: _____

How many children do you have? _____ N/A

Please list all ages:

Patient Responsibility Insurance Policies, And Disclosure Statement

Payment in full services and product are due at the time services are performed or products are ordered. As the patient/ guarantor, you are financially responsible for any fees and costs associated with any services or products you receive from our office.

I understand and agree that I am financially responsible for all charges for any and service rendered. This includes any medical service or visit, routine examination, testing and any other screening ordered by the doctor or staff.

I understand that while my insurance may confirm my benefits, confirmation of benefits is not a guarantee of payment and that I am responsible for any unpaid balance.

I understand and agree that it's my responsibility to know if my insurance has any deductible, copayment, co-insurance, out-of-network, usual and customary limit, prior authorization requirement or any other type of benefit limitation for the service I receive and I agree to make payment in full.

I agree to inform the office of any changes in my insurance coverage. If my insurance has changed or is terminated at the time of service, I agree that I am financially responsible for the balance in full.

Co-payment and deductible will be collected at the time of service. Professional fees, service fees, co-payment and deductible are NOT refundable. There will be a $ 35 fee for returned checks.

Patients who accumulate three or more missed appointment may be subject to discharged from our practice.

Produces performed in the office are considered the same as surgery by insurance companies and are billed as such. Additionally your office visits today may include the use of a scope for diagnostic purpose, allergies testing and hearing test. This is considered a diagnostic procedure, which will be coded to your Insurance Company as a **SURGICAL PROCEDURE** depending on your particular policy; your insurance company will pay all, part or none of the cost of the procedure.

CANCELLATION POLICY: This office has a policy of charging a fee for missing appointment or canceling with less than 24 hours notice. This policy is explained at the time of the first visit. The fee is $25.00. The purpose of this fee is to encourage our patient to take their appointment than the schedule as seriously as we do. That time is reserved for you, and if you do not keep the schedule then other patient who need 'same day "urgent visits, or earlier appointment than the schedule permits, are being obligated to wait longer than necessary. Obviously, acute health problems and family cries are expected. Cancellations of convenience or last minute schedule conflict will be your responsibility. We remain available to discuss this policy in general or individual circumstance. Thank you for understanding.

I also authorize my physician's office to provide my medical information to other organizations or entities for the Determination and payment of benefits. I authorize my physician's office to permit my Insurance companies or third party Payers to review/audit my medical chart if they so request. I assign benefits otherwise payable to me my physician, I Understand that I am financially responsible for the changes for any services rendered to me by my physician(s). They have accepted assignment. I further release my physician to release medical information concerning my treatments to my insurance carrier (s) and I authorize payment of medical benefits from those carriers to be made directly to my physician on claims for which they have accepted the assignment. I also understand that I am responsible for payment for services not covered by my Insurance Plan.

I have read and agree to the terms above:

Signature of Patient or Legal Representative Date:

Signature of Insurance Policy Holder Date:

Dwayne E. Rollins, M.D. P.C.

PATIENT DEMOGRAPHIC FORM

Today's Date: Primary Doctor:

PATIENT INFORMATION

Patient's last name: First: Middle: Marital status:

Is this your legal name? If not, what is your legal name? Former name: Birth date: Age: Sex:

☐ Yes ☐ No ☐ M ☐ F

Address:

Social Security no.: Home phone no.: Cell phone no.:

Occupation: Employer: Employer phone no.:

Referring Physician: Primary Care Physician:

How did you hear about us?

Would you like your results sent to your family doctor? Y/N (circle one) Pharmacy Information:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill: Birth date: Address (if different): Home phone no.:

Is this person a patient here? ☐ Yes ☐ No Is this patient covered by insurance? ☐ Yes ☐ No

Occupation: Employer: Employer address: Employer phone no.:

Please indicate primary insurance: |:

Subscriber's name: Subscriber's S.S. no.: Birth date: Group no.: Policy no.: Co-payment:

$

Patient's relationship to subscriber: [Choose an item] | Other: [Relationship to subscriber]

Name of secondary insurance (if applicable): Subscriber's name: Group no.: Policy no.:

[Secondary Insurance]

Patient's relationship to subscriber: |

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address): Relationship to patient: Home phone no.: Work phone no.:

I certify that the information given by me in applying for payment under Title XV11 of the Social Security Act is correct.
I authorize my physician to release to the Social Security Administration or its Intermediaries or carriers any information
Needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my
Behalf. I assign the benefits payable for physician services to my physician on claims for which they have accepted
Assignment and I authorize the physician to submit a claim to Medicare for payment on my behalf. I request that payment
under the insurance program be made to my physician on any bills for services furnished me by my physician for which
They have accepted assignment. I further release my physician to release medical information concerning my treatments to my insurance carrier (s)

Patient/Guardian signature Date