



Patient Label

Assignment of Benefits and Authorization

Patient Name: _____ Date of Service: _____

Assignment of Benefits

I authorize payment of benefits, including benefits of any applicable insurance policy or employee benefit plan or healthcare plan, for intraoperative monitoring services to Surgical Neuromonitoring Associates, Inc. (Surgimon), or to its retained physician service provider, Surgical Neuromonitoring Associates, PLLC. (Provider)

Authorization to Release Information

I hereby authorize Provider to release any information necessary to my health benefit plan or to its administrator regarding my medical procedure. I further authorize the Providers and their authorized representatives to (1) discuss my personal health information with the health insurer, employee benefit plan, or healthcare plan, or their authorized representatives; (2) file any necessary appeals, complaints, or claims with my health insurer, employee benefit plan, or healthcare plan, or their authorized representative; and (3) obtain copies of my health insurance policy, employee benefit plan, or healthcare plan.

ERISA Authorization

I hereby designate, authorize, and convey to Provider to the full extent permissible under law and under any applicable insurance policy, employee benefit plan, or employee healthcare plan: (1) the right and ability to act on my behalf in connection with any claim, appeal, right, or cause of action, including without limitation, any claim that may be brought pursuant to ERISA, that I may have under such insurance or benefit plan; and (2) the right and ability to act on my behalf to pursue such claim, right, or cause of action in connection with said insurance policy or benefit plan, including but not limited to the right to act on my behalf in respect to a benefit plan governed by the provisions of ERISA with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under law, to claim on my behalf, such benefits, claims, or reimbursement and any other applicable remedy.

Certification

I certify that I have read and understand the contents of this form. If I am not the patient, I certify that I am authorized by the patient to sign this form and accept its terms.

Signed:

Patient (If patient is a minor or unable to sign, please complete the following)

Date

Authorized Representative

Relationship to Patient