

# Ankle and Foot Centers of Western New York

*Buffalo, LeRoy, Batavia, Rochester*

*Phone: 585-250-0064*

*Fax: 585-672-9100*

## **ASSIGNMENT OF BENEFITS AND ERISA AUTHORIZATION**

### 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 Control Center and affiliated facilities (the “Provider”) and their authorized representatives (collectively hereinafter, “My Authorized Representatives”), and I appoint them as my authorized representative with the power to:

- ✓ File medical claims, appeals and grievances with the health plan
- ✓ File appeals and grievances with the health plan
- ✓ 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 the Provider is accurate as of the date set forth below and that I am responsible for keeping it updated.

### 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 Authorization/Client Retainer shall be as effective and valid as the original.

Patient (Guarantor) Signature: \_\_\_\_\_ Date \_\_\_\_\_

8745 Lake Street Road, LeRoy, NY 14492