Apex Gastroenterology, LLC
Rada Shakov, MD
501 Iron Bridge Road Suite 9
Freehold NJ 07728

ASSIGNMENT OF BENEFITS / ERISA AUTHORIZED REPRESENTATIVE FORM

Financial Responsibility

I have requested professional services from Apex Gastroenterology, LLC and Rada Shakov, MD ("Provider") on behalf of myself and/or my dependents, and understand that by making this request, I am responsible for all charges incurred during the course of said services. I understand that all fees for said services are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement unless other arrangements have been made in advance.

Assignment of Insurance Benefits

I hereby assign all applicable health insurance benefits to which I and/or my dependents are entitled to Provider. 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 hereby authorize Provider to submit claims, on my and/or my dependent's behalf, to the benefit plan (or its administrator) listed on the current insurance card I provided to Provider, in good faith. I also hereby instruct my benefit plan (or its administrator) to pay Provider directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to Provider, I hereby instruct and direct my benefit plan (or its administrator) to provide documentation stating such non-assignment to myself and Provider upon request. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make out the check to me and mail it directly to Provider.

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 Provider 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 Provider to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan, as my Authorized Representative: (1) the right and ability to act on my behalf in connection with any claim, right, or cause in action that I may have under such insurance policy and/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 and/ 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 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.

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

________________________________ ________________

Patient Signature Date

________________________________ ________________

Policyholder/Insured Signature Date

HIPAA PRIVACY AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et. seq., and regulations promulgated thereunder, as amended from time to time (collectively referred to as "HIPAA").

This authorization affects your rights in the privacy of your personal health care information. Please read it carefully before signing.

Apex Gastroenterology, LLC will not condition treatment payment, enrollment in a health plan, or eligibility for benefits, as applicable, on your providing authorization for the requested use or disclosure. YOU MAY REFUSE TO SIGN THIS AUTHORIZATION.

By signing this authorization you acknowledge and agree that Apex Gastroenterology, LLC may use or disclose any health care related documentation for the purpose(s) of treatment or management of the patient's health.

By signing this authorization you agree that Apex Gastroenterology, LLC or its Business Associates may disclose your personal health care information to a requesting entity or health care provider.

Further, by signing this authorization you acknowledge that you have been provided a copy of and have read and understand Apex Gastroenterology, LLC Privacy Notice containing a complete description of your rights, and the permitted uses and disclosures, under HIPAA. While Apex Gastroenterology, LLC has reserved the right to change the terms of its Privacy Notice, copies of the Privacy Notice as amended are available from Apex Gastroenterology, LLC at any of its offices.

In accordance with your rights under, and subject to certain restrictions imposed by, HIPAA, you may inspect or copy your PHI in the designated record set maintained by Apex Gastroenterology, LLC for as long as the PHI is maintained in the designated record set.

You have the right to revoke this authorization, in writing, at any time, except to the extent that Apex Gastroenterology, LLC has taken action in reliance on it. A revocation is effective upon receipt by Apex Gastroenterology, LLC of a written request to revoke and a copy of the executed authorization form to be revoked at the address listed above.

This authorization shall expire upon the earlier occurrence of: (a) revocation of the authorization, (b) a finding by the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights that this authorization is not in compliance with requirements of HIPAA, (c) complete satisfaction of the purposes for which this authorization was originally obtained, to be determined in the reasonable discretion of Apex Gastroenterology, LLC, or (d) six years from the date this authorization was executed.

By signing this authorization you acknowledge and agree that any information used or disclosed pursuant to this authorization could be at risk for re-disclosure by the recipient and no longer protected under HIPAA.
Apex Gastroenterology, LLC will provide the undersigned with a copy of this signed authorization at his or her request.

Acknowledged and agreed to by:

Patient Name: ____ Date:____________________________

Patient Signature: ____

LIMITED POWER of ATTORNEY

TO ENDORSE CHECKS and SIGN PAPERS TO EHANCE & EXPEDITE PAYMENTS
to ***Apex Gastroenterology, LLC*** for SERVICES RENDERED

I,____(name), living at my current address of
____
____(address)
do make, constitute and appoint Apex Gastroenterology, LLC and any of its duly authorized agents and employees as and to be the undersigned's name and to endorse any and all checks, drafts or money orders made payable to the undersigned alone or to the undersigned and Apex Gastroenterology, LLC with knowledge and approval of the undersigned with respect to emergency services and any procedures performed on the undersigned as a result of a hospitalization occurring from______to _____ (dates of hospitalization).

Furthermore, the undersigned allows Apex Gastroenterology, LLC or any of its agents or employees to sign any paper necessary to enhance and expedite payments to Apex Gastroenterology, LLC. This shall include all insurance forms.

The undersigned by these presents does thus give and grant Apex Gastroenterology, LLC, as attorney, the full power and authority to do and perform all acts necessary as the undersigned might or could do personally insofar as endorsing and cashing checks as well as any other documents with respect to benefits claimed as a result of the aforementioned hospitalization and emergency services & procedures.

The undersigned does hereby ratify and confirm any and all actions taken by said attorney in accordance with this limited power and which the said attorney shall do or cause to be done by virtue of those present.

WITNESS my hand this _________ day of__________,_______.

Patient's Signature: ____

Witness Signature: ____

Witness Signature: ____

RECORDS RELEASE AUTHORIZATION

Patient: ______________________________

Date: _________________________________

I hereby authorize the release of my health records to:

Apex Gastroenterology, LLC
501 Iron Bridge Rd Suite 9
Freehold, NJ 07728

Patient signature   Date