Renue Plastic Surgery, LLC
Renue Surgery Center, LLC
Renue Surgery Center Waycross, LLC

Appointment of Representative

I _____ the undersigned (the "Patient"), having healthcare benefit coverage through a group (including a self-funded and employer/employee benefit plan), Medicare, Medicaid and/or individual healthcare plan (collectively, the "Plan"), hereby appoint and assign as my designated authorized representative, _____ (the "Provider"), and its billing agent the right to pursue payment for benefits, and take any and all necessary steps, including pursing administrative appeals, requesting disclosures and remedies, filing suit and all causes of action wholly in my stand for benefit payment of all medical benefits otherwise payable to the Patient for medical services, treatments, therapies, and/or medications rendered or provided by the Provider under the Plan, regardless of the Provider's managed care network participation status. The Patient hereby appoints the Provider, _____ its billing agent, and/or the Provider's appointed business associates, the Patient's rights, title, and interests in and to, and related to the recovery of, any and all benefits which the Patient is entitled to receive under the Plan or insurance policy, and authorizes the Provider to release all medical information necessary to pursue and process the Patient's benefits and claims thereunder. I certify that the health insurance information that I provided is accurate 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) to be paid in full compliance of governing laws. I also hereby instruct my benefit plan (or its administrator) to pay the 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 plan administrator) to provide governing plan documentation stating such non-assignment to myself and the Provider upon request and its standing to governing laws. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make the check payable to me and mail it directly to the provider. I understand there are state and federal consumer protections that support even for out of network providers that may be associated with my care or surgery, that I am responsible for co-payments, co-insurance, and deductibles at no more than my in-network cost share rate. I understand, agree and hereby certify that I am obligated to pay, as charged and billed for global service charges, regardless if the above services are covered under my health insurance or plan. I understand that "Deductible" is defined, under the Uniform Glossary from ERISA & the Patient Protection & Affordable Care Act (ACA) as: *"The amount you owe for healthcare services your health insurance or plan covers before your health insurance or plan begins to pay,"* and that I have no knowledge of any plan exclusion or limitation for the charges for healthcare services rendered by the above listed provider, in case that I can't afford to pay for 100% deductible. I understand the payments are due at the time of the services unless otherwise applicable to any PPO or ACA discount once my claim for benefits is processed in full compliance with plan terms and governing laws. I understand I am fully protected against any unexpected medical bills or charges by my Provider's applicable ACA or indigency discount policy; including any non-compliant or arbitrary and capricious PPO Discounts or Re-pricing Discounts received from my health insurance plan. My satisfaction is guaranteed in connection with my provider's proactive reasonable efforts to collect or make a good faith determination for ACA Discount qualifications solely based on my unique ability to pay and individual health need. I hereby assign billed charges for healthcare services rendered as my legal claims to the above listed Provider as full payment, as my authorized representative, and an ERISA or ACA claimant, to claim or legally pursue proper payment of benefits from my health plan or insurance.

I hereby designate, authorize and appoint the Provider, _____, its attorneys or other designated business associate and as my authorized representative 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; (3) to file and participate in any administrative or judicial review process; (4) to give the Provider and its attorneys standing to pursue payment and file suit for benefits and any fiduciary breach and all causes of action available under ERISA and Section 502, 27 § U.S.C. 1132(a). (5) to pursue all necessary benefit payments, appeal rights, remedies and all causes of action, wholly in my stead; (6) to pursue a claim for benefits and to recover all applicable penalties for any fiduciary breach or failure by my plan, its fiduciary and/or its claims administrator to comply with 29 U.S.C. § 1132 and (7) allow a photocopy of my signature to be used to process insurance claims. This authorization includes all entitled benefit payments, rights and remedies due under my governing Health and Welfare Plan or policy, to include all benefits entitled for all services rendered and ordered by my treating physician. This authorization will remain in effect until all benefits are paid in full compliance of applicable federal and state laws. I hereby confirm and ratify all actions taken by my authorized representative pursuant to the authority granted herein. This order will remain in effect until revoked by me in writing. I authorize Provider, _____, its attorneys, or designated business associate to make any request, file and obtain appeals information, receive any notice in connection with my healthcare services, benefits, appeal, take legal action or other rights, wholly in my stead. Further, I hereby authorize my plan administrator, fiduciary, insurer, and/or attorney to release to the above named health care provider or its designated business associated any and all relevant Plan and claim documents, requested disclosures, complete insurance policy, and/or settlement information upon written request from the Provider, its attorneys or designated business associates in order to secure and claim such medical benefits. I authorize the release of disclosure of my protected health information to my authorized representative in order to secure and claim medical benefits due; (1) obtain information or submit evidence regarding the claim to the same extent as me; (2) make statements about facts or law; (3) act as my authorized representative in connection with filing, providing or receiving notice of any claim or appeal proceedings, to include any external review by applicable state or Federal External Review Process. I understand that I will be held financially responsible for all fees accumulated for collection agency fees. Administrative fees, attorney fees and court costs incurred by the Provider listed above for any delinquent account requiring outside collection assistance, to the fullest extent of the law. I understand revocation of this appointment will not affect any action taken in reliance on this appointment before my written notice of revocation is received. Unless revoked in writing, this assignment is valid for any and all requested administrative and judicial reviews rightfully due me under my governing plan or policy and to the fullest extent permitted by law. A photocopy of this assignment is to be considered valid, the same as if it was the original. I understand that, by signing this form, I am confirming my appointment of my authorized representative, the scope of my authorized representative's authority, and the option of revoking of this appointment. I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

_____ _____ _____

Patient/Guardian/Insured Signature Employer Group Name Covering Benefits Date