

**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 SportsCare et al, (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 on my behalf in connection with any claim, right, or cause in action that I may have under such insurance 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 above named 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 above named Provider and their 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/Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Name (printed)

(8/2018)

**NOTICE OF PRIVACY PRACTICES (HIPAA)**

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I understand that I may revoke this consent in writing at any time, except where you have taken action relying on this consent. If you have any questions about our Notice of Privacy Practices, please contact our Privacy Officer at (973)887-9000

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**RELEASE OF INFORMATION DESIGNATED PERSONAL REPRESENTATIVE:**

**Ordinarily, discussion of medical records or billing information would not be disclosed to anyone but yourself over the phone. However, with your consent, our staff will speak with your choice of a designated representative. Please understand that you are waiving your right to confidentiality if this consent is given.**

\_\_\_\_\_ **INITIAL HERE TO GIVE CONSENT.** The person below referenced representative, for purposes of SportsCare, may communicate on my behalf regarding treatment, insurance verification, authorization, referral and insurance payment or denial. This representative designation is effective from initial evaluation date through account reconciliation.

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

\_\_\_\_\_ **INITIAL HERE TO DECLINE CONSENT**

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\_\_\_\_\_ **INITIAL HERE TO GIVE CONSENT,** for SPORTSCARE office staff to leave appointment reminders (including date and time) on my voicemail/email and any medical information.

Phone #: \_\_\_\_\_

Email: \_\_\_\_\_

\_\_\_\_\_ **INITIAL HERE TO DECLINE CONSENT**