

# Northern Jersey Plastic Surgery Center, LLC.

Troy E. Callahan, M.D.

## ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND/OR OTHER HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

I hereby assign and convey directly to the above-named health care provider, as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by the above-named health care provider, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above-named health care provider to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator, fiduciary, insurer, and/or attorney to release to the above-named health care provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named health care provider or its attorneys in order to claim such medical benefits.

In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to the above named health care provider any legal or administrative claim or chose an action arising under any group health plan, employee benefits plan, health insurance or tortfeasor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the above-named health care provider (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey the above-named provider all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or medications provided by the above-named health care provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (above-named provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original.

### **I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT**

**Patient's name** \_\_\_\_\_

**PATIENT SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

# NORTHERN JERSEY PLASTIC SURGERY CENTER, LLC

This Assignment of Benefits/Designated Authorized Representative authorization/ Limited Special Power of Attorney shall remain in full force and effect for all current and future dates of service, until such time that all rights have been exercised under applicable Federal and State law as determined by Providers. I may revoke or withdraw this authority upon written notice to the Providers. In the event of any revocation, I will be responsible for payment of all outstanding amounts then due to the Providers.

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

## **Certificate of Acknowledgment of Notary Public**

STATE OF NEW JERSEY  
COUNTY OF \_\_\_\_\_

This document was acknowledged before me on this \_\_\_\_\_ date of \_\_\_\_\_ in the year  
20\_\_\_\_\_ by

\_\_\_\_\_  
Name of Patient

[Notary Seal, if any]:

\_\_\_\_\_  
(Signature of Notarial Office)  
Notary Public for the State of New Jersey  
My commission expires: \_\_\_\_\_

# NORTHERN JERSEY PLASTIC SURGERY CENTER, LLC

Dear Patient,

Please be advised that the healthcare plans in which our practice is a participating provider and the facilities with which our practice is affiliated are listed on our company website at **callahanplasticsurgery.com**. This information is also available to you upon request at our offices.

If your health plan is not listed on our website or communicated to you at the time of your appointment as a benefit plan that we participate in, please note, **Troy Callahan, M.D.**, does not participate in the network of your healthcare plan. As an out-of-network physician, **Troy Callahan, M.D.** has not agreed to any set rate that your healthcare plan may pay, and he may charge more. The estimated amount that will be billed to you is available upon request. However, If, unforeseen medical circumstances arise when services are provided, the amount that will be billed for services rendered may be higher.

Depending on your specific plan, you may have a financial responsibility for services related to your out-of-network deductible, co-pay and/or co-insurance. Additionally, you may be responsible for the portion of our charges that are not covered by your insurance and we recommend that you contact your insurance carrier for further information regarding the costs under your specific plan.

As a courtesy to our patients, we will bill your insurance company directly for reimbursement for our services. Occasionally, the insurance company will either mail the check or deposit our reimbursement for surgical fees directly to you. In these circumstances, we kindly request that you mail us a copy of the explanation of benefits (EOB) with the check from your insurance company endorsed by you, or in the case of monies being directly deposited, a check from you in the exact amount stated in the EOB made payable to **Troy Callahan, M.D.** Failure to comply will force your account to become past due. This may result in the amount owed being turned over to a collection agency and may adversely affect your credit.

We thank you for your cooperation in this matter and we are happy to assist you in any way we can.

I acknowledge that **Troy Callahan, M.D.** is an out-of-network provider and I elect to obtain services from **Troy Callahan, M.D.** I understand it is my responsibility to remit any funds rendered to me by my insurance carrier as payment for medical services provided to me by **Troy Callahan, M.D.** I hereby authorize **Troy Callahan, M.D.** or their authorized representatives, to appeal and pursue all other legal rights for any and all unpaid claims on my behalf with my insurance company. I also acknowledge that I have read the above information regarding fee disclosures.

PATIENT'S NAME \_\_\_\_\_

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SIGNATURE

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DATE