ELEVATE Health Clinics, LLC

ACUITY BRAIN CENTER

Assignment of Benefits: Assignment of Cause on Action: Contractual Lien

The undersigned patient and/or responsible party, in consideration of treatment rendered or to be rendered and for deferred payment, irrevocably and exclusively assigns, grants, and conveys, to Dr. Mandeep Chahil, M.D., a lien and assignment of any and all claims, causes of action, and right to any proceeds and/or benefits that the patient may have against any other person, entity, and/or insurance company for reimbursement and/or payment of the medical charges incurred with all the following rights, power, and authority:

Release of Information: You are authorized to release information concerning my condition and treatment to my insurance company, attorney or insurance adjustor for purposes of processing my claim for benefits and payment for services rendered to me.

Irrevocable Assignment of Rights: *You are assigned the exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company for the terms of the policy, including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payment, and prosecute and receive penalties, interest, court loss, or other legally compensable amounts owned by an insurance company in accordance with Article 21.55 of the Texas Insurance Code to cooperate, provide information as needed, and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request.*

Demand for Payment: To any insurance company providing benefits of any kind to me/us for treatment rendered by the physician/ facility named above within 5 days following your receipt of such bill for services to the extent of such bills are payable under the terms of the policy. This demand specifically conforms to Sec. 542.057 of the Texas Insurance Code, and Article 21.55 of the Texas Insurance Code, providing for attorney fees, 18% penalty, court cost, and interest from judgment, upon violation. I further instruct the provider to make all checks payable to Elevate Health Clinics, LLC and to 5207 Heritage Avenue Colleyville, TX 76034.

Third Party Liability: If my injuries are the result of negligence from a third party, then I instruct the liability carrier to issue a separate draft to pay in full all services rendered, payable directly to Elevate Health Clinics, LLC and to send any and all checks to 5207 Heritage Avenue Colleyville, TX 76034.

Statute of Limitations: I waive my rights to claim any statute of limitations regarding claims for services rendered or to be rendered by the physician/facility named above, in addition to reasonable cost of collection, including attorney fees and court cost incurred.

Limited Power of Attorney: I hereby grant to the physician/facility named above power to endorse my name upon any checks, drafts, or other negotiable instrument representing payment from any insurance company representing payment for treatment and healthcare rendered by the physician/facility named above. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my/our account or forwarded to my/our address upon request in writing to the physician/facility named above.

Rejection in Writing: I hereby authorize the physician/clinic named above to establish a PIP or UM/UIM claim on my behalf. I also instruct my insurance carrier to provide upon request to the provider/clinic named above, any rejections in writing as they apply to my lack of PIP or UM/UIM coverage. I allege that electronic signatures are not adequate proof of rejection, and are invalid to establish rejection, and instruct my carrier to provide only copies of my original signature regarding rejection as evidence of rejection of PIP or UM/UIM.

Termination of Care: I hereby acknowledge and understand that if I do not keep appointments as recommended to me by my caring doctor at this clinic, he/she has full and complete right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time. If during the course of my care, my insurance company requires me to take an examination from any other doctor, I will notify this physician/facility immediately. I understand the failure to do so may jeopardize my case.

Signature of Patient and/or Responsible Parties Date

ELEVATE Health Clinics, LLC

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Patient Last Name | First Name | Middle Initial | Birthdate

Date of Injury | Attorney

Financial Disclosure Notice Acknowledgement

I have read the **Financial Disclosure Notice** provided to me and understand my financial obligations. I agree to pay the amounts required of me for any fees or services incurred at ***Elevate***. I am over 18 years of age or I am the parent or guardian of the patient. I give permission for ***Elevate*** (Elevate Medical Clinics) to bill my insurance (if applicable) and release information to my insurance, if necessary, for payment of claims.

Signature of Patient and/or Responsible Parties | Date | Relationship to Patient if Minor

Notice of Privacy Practices Acknowledgement

By signing below, you acknowledge that you have received the **Notice of Privacy Practices** and you consent to the use and disclosure of your medical information except as expressly stated below. You understand that ***Elevate*** has the right to change its **Notice of Privacy Practices** and that you may contact ***Elevate*** at any time if you have any questions.

I hereby request the following restrictions on the use and/or disclosure of my information. I understand that you are not required to agree to my requested restrictions and will notify me, in writing, if my request(s) is denied.

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Patient Confidentiality and Treatment of Private Medical Information

1. Please list people (and their relation to you) to whom we may release information about your medical condition and/or treatment. Please include anyone who may pick up prescriptions, reports, x-rays, etc. for you. ***Please note: for minors, the parents &/or legal guardians must be listed below, even if completed by a parent or legal guardian.***

_____________________ _____________________

_____________________ _____________________

_____________________ _____________________

2. How can we communicate confidential information (e.g., lab results, referrals, diagnostic test results, billing inquiries)?

   Home phone? Yes No **Work phone?** Yes No **Cell Phone?** Yes No **E-Mail?** Yes No

   Email Address (please print clearly): _______________________________

Signature of Patient and/or Responsible Parties | Date | Relationship to Patient if Minor