Desert Endoscopy Center

603 W. Baseline Road Suite 101 Mesa, AZ 85210
Phone: (480) 969-0405

You are schedule for your procedure(s) on _____

Your procedure is scheduled with:

❑ Dr. Patel	❑ Dr. Sawyer	❑ Dr. Lowe
❑ Dr. Saperstein	❑ Dr. Mahajani	❑ Dr. Davis
❑ Dr. Sahai	❑ Dr. Kavathia	❑ Dr. Khosla
❑ Dr. Grade	❑ Dr. Verma	

Your Procedure time is _____ Please check in no later than _____
Should you have any questions please call your physicians office

You will receive sedation for your procedure. This requires you to have a responsible adult (18 or older) to drive you or accompany you home after your procedure. This can be family, friend, neighbor, or medical transport. If you are not accompanied by a responsible adult, you must make arrangements with medical transport to drive you home. Taxi, Uber, Lyft, etc. are not medical transport.

Please visit: http://desertendoscopy.com/patient-forms to print your
Paper work to fill out and bring with you to your procedure.

WELCOME

We have provided this information in order to make your procedure as easy and comfortable as possible.

Desert Endoscopy Center

WHAT IS ENDOSCOPY?

Endoscopy (also known as GI Endoscopy) is a procedure that enables your physician to diagnose and treat digestive diseases by examining the lining of your gastrointestinal tract. Endoscopy is more than x-ray films for detecting inflammation, ulcers, or tumors of the digestive tract. Upper Endoscopy, often called Esophagogastroduodenoscopy (EGD) or Panendoscopy, focuses on the upper part of the digestive tract. Lower Endoscopy, often called Colonoscopy, examines the large intestine.

WHY ARE ENDOSCOPIES DONE?

Upper endoscopies are usually performed to evaluate symptoms of upper abdominal pain, nausea, vomiting, or difficulty swallowing. It is also the best test for finding the cause of bleeding from the upper gastrointestinal tract. Similarly, lower endoscopies help determine the cause of bleeding from the lower digestive tract. Lower endoscopies are also performed to screen for colorectal cancer and to evaluate symptoms of lower abdominal pain and persistent diarrhea.

PREPARING FOR YOUR PROCEDURE

Your physician will give you detailed instructions regarding the preparation for your procedure. Be sure to confirm what time you are to stop eating or drinking the morning of your procedure. Medications should be taken at the recommendation of your physician. If you are taking any medications for your heart, blood pressure, breathing, or for diabetes, be sure to ask your physician if you are to take any of them the day of your procedure.

Notify the Center and the physician's office if you should become ill prior to your procedure.

Desert Endoscopy Center is not responsible for lost items. Therefore, leave all items you consider to be valuable, such as jewelry, watches, rings, earrings, wallets, purses, cell phones etc., at home or with the responsible adult who will be driving you home.

YOUR PROCEDURE

The nurses at Desert Endoscopy Center need time to admit you and get you prepped prior to your procedure. **If your physician gave you a registration packet for Desert Endoscopy Center, please complete it and bring it in with you at the time of your procedure. You may also print a copy of your registration packet by going to www.desertendoscopy.com and clicking on For your Visit/Download Forms.**

Your physician's office provided you a copy of your Patient's Bill of Rights and Responsibilities. **You must read this in advance of the day of your procedure.**

If you have any Advanced Directives, such as a Living Will or Power of Attorney, you will need to bring a copy of it with you at the time of your procedure.

In most cases, you will receive medication to make you more comfortable during your procedure. Therefore, you will not be able to drive yourself home or return to work that day. This requires you to have a responsible adult (18 or older), to drive you or accompany you home after your procedure. This can be family, friend, neighbor, etc. If you are NOT ACCOMPANIED BY A RESPONSIBLE ADULT, you must make arrangements with Medical Transport to drive you home. Taxi, Uber, Lyft, etc., are not medical transport.

After your procedure, you will remain in the recovery room until you are ready for dismissal. Your approximate stay at the Center may range from 1-3 hours.

Instructions following the procedure will be given at the time you are discharged from the Center. It is important that you follow these instructions and call your physician if you have any problems following the procedure.

INSURANCE AND BILLING

Please be sure to bring your insurance cards and picture ID with you. Desert Endoscopy Center will bill your insurance as a courtesy; however, payment of co-pays/deductibles/co-insurance is expected at the time of service. Any balance due on your account after insurance pays is the patient's responsibility and should be paid promptly. Self-pay patients are required to pay the amount in full at the time of service.

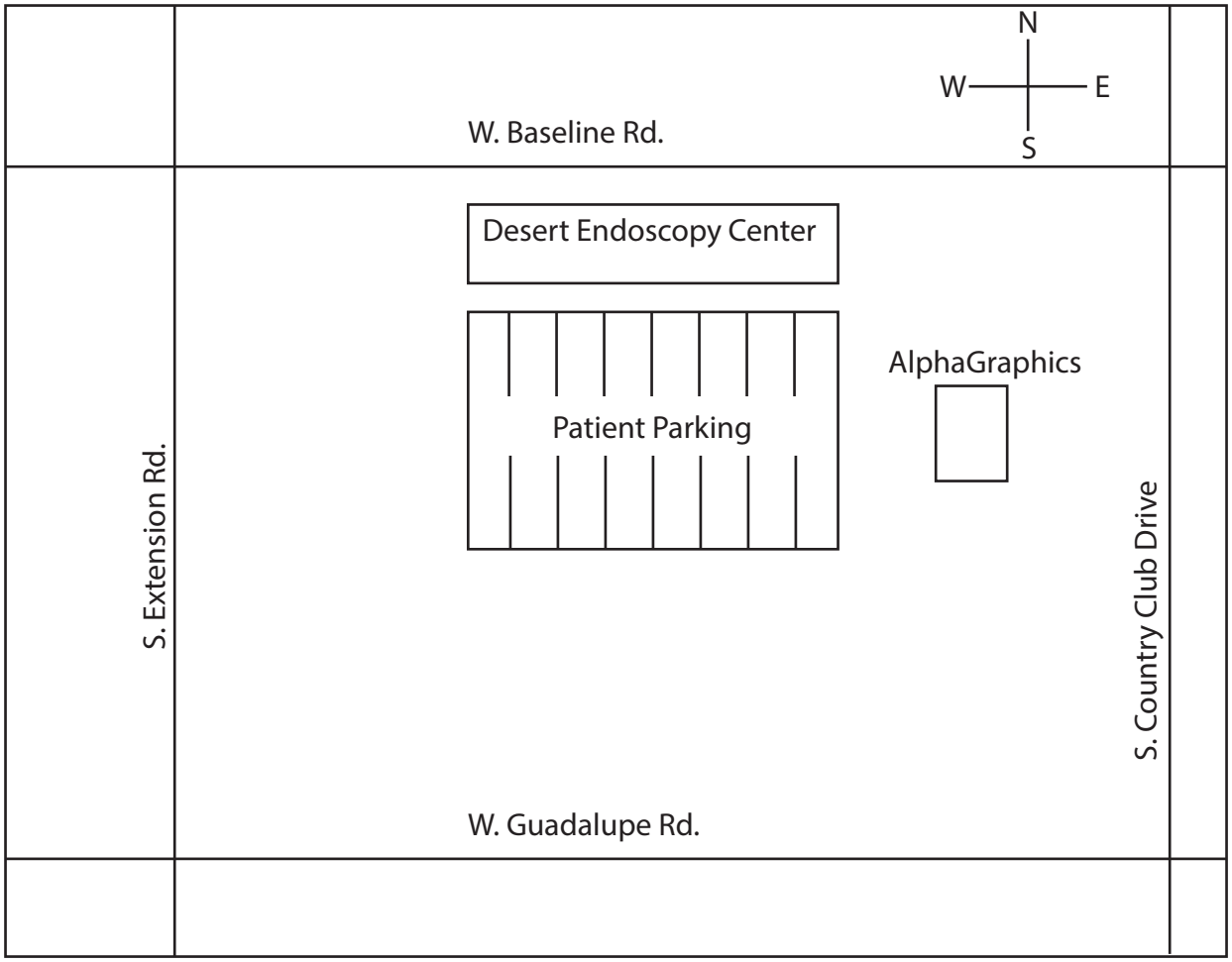
As our patient, you are our most valued asset. We appreciate any comments and concerns you may have. If any questions arise, please do not hesitate to bring them to our attention. It is our goal to provide you the very best care available. Thank you for scheduling your procedure at **Desert Endoscopy Center.**

SEE REVERSE SIDE FOR OFFICE LOCATION

LOCATION

Desert Endoscopy Center

Between S. Extension and N. Arizona Ave.
on south side of Baseline Road just West of
Alphagraphics.



PATIENT REGISTRATION FORM

PLEASE USE BLACK INK ***PLEASE PRINT CLEARLY***

Desert Endoscopy Center

_____ _____ _____
Last Name First Name M.I.

_____ _____ _____ _____ _____
Billing Address Apt # City State Zip

(_____) _____ – _____ (_____) _____ – _____ Sex: ☐ Male ☐ Female
Home Phone Mobile Phone

_____ / _____ / _____ _____ – _____ – _____ _____
Date Of Birth Social Security Number Marital Status Name of Spouse

_____ (_____) _____ – _____
Name of Employer Employer Phone

_____ _____
Email Address Family Care Physician

MEDICAL INSURANCE INFORMATION

It is your responsibility to tell us in advance if your insurance company requires pre-certification of procedures. Please keep us informed of changes in your insurance. Claims will be filed for you.

PRIMARY INSURANCE

Name of Insurance: _____
ID or Policy Number: _____
Group Number: _____
Policy Holder's Name: _____
Policy Holder's Address: _____
Policy Holder's Birth Date: _____
Relationship to Patient: _____

SECONDARY INSURANCE

Name of Insurance: _____
ID or Policy Number: _____
Group Number: _____
Policy Holder's Name: _____
Policy Holder's Address: _____
Policy Holder's Birth Date: _____
Relationship to Patient: _____

I hereby acknowledge that the information provided above is correct.

_____ _____
Patient's Signature Date

MEDICAL HISTORY QUESTIONNAIRE

Please complete **both sides** of this form **prior** to arrival to expedite your admission process.

Desert Endoscopy Center

Last Name _____ First Name _____ M.I. _____

Scheduled Endoscopy Procedure(s)

- ☐ EGD (upper Endoscopy)
- ☐ Enteroscopy
- ☐ Colonoscopy
- ☐ Ileoscopy
- ☐ Sigmoidoscopy
- ☐ Other _____

Reason for Procedure(s) ☐ Screening only *(no symptoms)*

Personal history of

- ☐ Colon polyps
- ☐ Crohn's Disease
- ☐ Esophageal varices
- ☐ Colon cancer
- ☐ Barrett's esophagus
- ☐ Ulcerative Colitis
- ☐ Recent Ulcer

Symptoms

- ☐ Nausea
- ☐ Trouble swallowing
- ☐ Acid reflux
- ☐ Stool incontinence
- ☐ Blood in stool
- ☐ Anemia
- ☐ Vomiting
- ☐ Painful swallowing
- ☐ Bloating/Gas
- ☐ Diarrhea
- ☐ Trace bleeding
- ☐ Weight Loss
- ☐ Vomiting blood
- ☐ Heartburn
- ☐ Constipation
- ☐ Bloody diarrhea
- ☐ Black stools
- ☐ Bleeding with bowel movements
- ☐ Change in bowel pattern: Describe (from what to what) _____
- ☐ Abdominal pain: Location (right, left, upper, lower, center, etc.) _____
- ☐ Finding on: ☐ Ultrasound ☐ CT scan ☐ Barium study ☐ Other _____

Family History of:

- ☐ Colon cancer
- ☐ Colon polyps Who: _____ Age when diagnosed _____
- ☐ Other reason not listed: _____

Past Endoscopy Procedures (type, date, physician) _____

Allergies to medications or other substances: ☐ Latex ☐ _____

Current Medications List **name**, **dose**, and **frequency** (twice a day, 3 times a week, etc.) Include over the counter and herbal medications.

_____

_____

_____

_____

If you are currently taking any **blood thinners**, including over the counter aspirins or anti-inflammatory medications, it is necessary for you to determine **if** and **how long** they are to be discontinued, prior to your procedure, by discussing it with your physician, at the time you are scheduled. If you have not done so, please contact your physician's office for clarification.

If you are currently taking medication to control Diabetes, either **insulin** or **pill form**, it is necessary for you to determine how to manage your medication the day before and the day of your procedure, by discussing it with your physician, at the time you are scheduled. If you have not done so, please contact your physician's office for clarification.

Current weight: _____

Past Medical History (please describe)

- ☐ Cardiovascular disorder: _____
- ☐ High Blood Pressure ☐ Endocarditis ☐ Heart valve disorder
- ☐ Pulmonary disorder: _____
- ☐ Neurological disorder: _____
- ☐ Endocrine disorder: _____
- ☐ Diabetes: (insulin?) _____
- ☐ Liver disorder: _____
- ☐ Bleeding disorder: _____
- ☐ Cancer: _____
- ☐ Renal disorder: _____
- ☐ Musculoskeletal disorder: _____
- ☐ Other: _____

Females

☐ LMP date: _____ ☐ Post Menopausal/Sterile ☐ Currently pregnant ☐ Breastfeeding

Prosthesis / Implants

- ☐ Artificial heart valve ☐ Pacemaker ☐ Automatic internal cardiac defibrillator
- ☐ Artificial joint replacement: Location _____
- ☐ Orthopedic implants: Location (pins, rods, screws, plates) _____
- ☐ Other implants: (type and location) _____
- ☐ Prosthetic devices: (type and location) _____

Past Surgeries / Hospital Procedures: List year and type of occurence

_____

_____

_____

_____

Adverse Reactions to any prior anesthesia/sedation: (please describe) _____

_____

If there has been any **significant** change in your medical history, since your last office visit, it is necessary for you to contact your physician's office to update your physician with this information, **prior** to your visit to our facility.

Please complete both sides of this form

Desert Endoscopy Center

EXPLANATION OF BILL

The total cost of your medical services may be comprised of up to five (5) fees, since the provider of each service bills each fee separately.

1. You will receive a statement from **Desert Endoscopy Center**, which covers the cost of providing the facility, technicians, nurses, equipment, and supplies involved in the performance of your services. Co-pays, deductibles, and co-insurances will be collected at the time of service. However, this is only an estimation of your patient responsibility. If there is a balance after your insurance pays,you will receive a statement for that amount. Please make arrangements to pay the portion that is not covered by your insurance when you receive your statement. For your convenience, we accept all major credit cards, Care Credit,check, and cash. If you do not have insurance and are a self-pay patient, you must contact the billing office to make payment arrangements prior to your procedure. For billing questions, please contact us at 480-969-0405 extension 211 or extension 225.

2. You will receive a statement from your **Endoscopy Physician** for professional fees that include performing the Endoscopy procedure, supervising, interpreting, and consulting with you and your referring physician. For billing questions pertaining to this service, please call your physician's office.

3. You may receive a statement from a **Pathology/Laboratory service** for the interpretation of any specimens (biopsies,polyps, brushings, and stool specimens) that may have been collected during your procedure. For billing questions pertaining to these services, please call the phone number located on your bill.

4. You will receive a separate statement from **DEC Anesthesia LLC** for services provided by the Certified Registered Nurse Anesthetist for providing anesthesia services during your care at the center. Please be advised that while best efforts will be made to provide in-network services, some charges may be processed as out-of network by your insurance company. For billing questions for these services, please call 602-308-7815.

_____ _____

Patient's Signature Date

Desert Endoscopy Center

AUTHORIZATION FORM

FINANCIAL AGREEMENT

In the event that my insurance will pay all or part of the Desert Endoscopy Center (DEC) (the Facility) charges, the facility is authorized to submit a claim for payment to my insurance carrier. The Facility is not obligated to do so, unless under contract with the insurer or bound by a regulation of a State/Federal agency, to process such claim. DEC expects payment of co-pays/deductibles/co-insurance at the time of service. Self-pay patients are required to pay the amount in full at the time of service. There will be a $25.00 fee charged to your account for any checks returned for insufficient funds.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign benefits to be paid on my behalf to DEC for services rendered. I guarantee prompt payment of all charges incurred, balances due after insurance payments are made, and charges not paid within a reasonable period of time by my insurance or third party payer. I certify that the information given regarding insurance information coverage is correct.

COLLECTIONS NOTICE

Patient and/or guarantor agrees to pay all cost of collections including attorney fees, collection fees, and contingent fees to collection agencies of not less than 32% of the delinquent balance, such contingency fee will be added and collected by the collection agency immediately upon our referral of your account to the collections agency of our choice.

RELEASE OF MEDICAL RECORDS

I authorize the Center rendering service to release all or part of my medical records where required/permitted by law or government regulation, when required for submission of any insurance claim for payment of services or to any physician(s) responsible for continuing care.

DISCLOSURE OF OWNERSHIP NOTICE

I have been informed that the physician who is rendering service to me may have an ownership interest in this facility. DEC is making this disclosure in accordance with federal regulations.

PATIENT RIGHTS AND RESPONSIBILITIES

I hereby acknowledge that I received verbal and written information regarding the Patient's Bill of Rights and Responsibilities prior to my procedure.

CERTIFICATION OF PATIENT INFORMATION

I reviewed my patient demographic and insurance information on this date and verified that all information reported is correct.

PROCEDURE AND BILLING COMMUNICATION AUTHORIZATION

I hereby authorize DEC and/or the physician performing my procedure today to communicate information regarding my procedure/ results of my procedure/billing information to:

- My spouse/family member/other Name(s): _____Initials _____
- Leave a voice mail or message: ☐ Yes ☐ No Initials _____

ADVANCE DIRECTIVES

- I have an Advanced Directive: ☐ Yes ☐ No ☐ Copy Provided
- I would like more information about Advanced Directives ☐ Yes ☐ No ☐ Information Provided

The undersigned certifies that he/she has read and understands the foregoing and fully accepts all terms specified above.

_____ _____

Print Name | Signature of Patient or Responsible Party

_____ _____

Date Signed | Relationship to Patient

Desert Endoscopy Center

Understanding Screening vs. Diagnostic Colonoscopy

A colonoscopy is considered **screening** for patients with no signs or symptoms and are appropriate for screening based on age, family history of colon cancer or ten years since your last colonoscopy.

A colonoscopy is considered **diagnostic** for evaluation of signs and symptoms including but not limited to rectal bleeding, change in bowel habits, diarrhea, anemia, abdominal pain, abnormal imaging etc.

Insurance companies also consider a colonoscopy diagnostic for a stool test positive for occult blood, positive FIT or positive Cologuard.

Insurance companies consider a colonoscopy **diagnostic** if it is done for a history of polyps.

Insurance companies may approve a colonoscopy under "Screening" benefits but may consider it diagnostic if polyps are found. The claim may be processed as a diagnostic procedure.

Prior to scheduling your colonoscopy, you should contact your insurance company to check your benefits for a colonoscopy.

Physicians follow the recommended guidelines for coding. The indication for the exam is determined prior to performing the exam. It cannot be changed after the exam, based on patient's insurance benefits.

Please call our billing department at **602-264-9100** if you have any questions.

Acknowledgment:
I have read this notice and I understand the disclosure that it contains.

_____ _____
Printed Name of Patient Date of Birth

_____
Signature of Patient

_____
Date

NOTICE OF PRIVACY PRACTICES

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. You have the right to obtain a paper copy of this Notice upon request.

Desert Endoscopy Center

Patient Health Information
Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information.

How We Use Your Patient Health Information
We use health information about you for treatment, to obtain payment, and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose the information even without your permission.

Examples of Treatment, Payment, and Health Care Operations
Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care.
Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan.
Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, and to assess the care and outcomes of your case and others like it.

Special Uses
We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Other Uses and Disclosures
We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the following purposes:
Required by Law: We may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.
Research: We may use or disclose information for approved medical research.
Public Health Activities: As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.
Health oversight: We may be required to disclose Information to assist in investigations and audits, eligibility for government programs, and similar activities.
Judicial and administrative proceedings: We may disclose information in response to an appropriate subpoena or court order.
Law enforcement purposes: Subject to certain restrictions, we may disclose information required by law enforcement officials.
Deaths: We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.
Serious threat to health or safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
Military and Special Government Functions: If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.
Workers Compensation: We may release information about you for workers compensation or similar programs providing benefits for work-related injuries or illness.

In any other situation, unless otherwise permitted by law, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

Individual Rights
You have the following rights with regard to your health information. Please contact the person listed below to obtain the appropriate form for exercising these rights.
Request Restrictions: You may request restrictions on certain uses and disclosures of your health information. We are not required to agree to such restrictions, but if we do agree, we must abide by those restrictions. Also, if you have paid for your health care treatment out-of-pocket and in full, and if you request that we limit disclosure of your information to a health plan for purposes of payment or health care operations, we will abide by your request.
Confidential Communications: You may ask us to communicate with you confidentially by, for e
sending notices to a special address or not using postcards to remind you of appointments.
Inspect and Obtain Copies: You may request that we provide copies of your PHI in a format other than photocopies. We will use the form you request unless we cannot practically do so. We may charge a reasonable fee for copies of PHI based on our costs for postage and for a custom summary or explanation of PHI. You will receive notification of any fees prior to Releasing your PHI with an opportunity to modify your request in order to reduce the fee. In some cases, we may deny your request, and will tell you reasons in writing and explain your right to have the denial reviewed. If you seek a review, a licensed healthcare provider chosen by us will review your request. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.
Amend Information: If you believe that information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing information or add the missing information.
Accounting of Disclosures: You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or health care operations.
Notification of Breach: You have the right to be notified in the event we discover that a "breach" of your unsecured protected health information has occurred. In that circumstance, we will notify you promptly with the necessary information.

Our Legal Duty
We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect.

Changes in Privacy Practices
We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice on our website, in the waiting area and each examination room. You can also request a copy of our Notice at any time. For more information about our privacy practices, contact the person listed below.

Complaints
If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Contact Person
If you have any questions, requests, or complaints, please contact: Samantha Dillon, RN Administrator

Effective Date: September 23, 2013

I,_____,
hereby acknowledge receipt of the Notice of Privacy Practices given to me.

Signed:_____Date:_____

If not signed, reason why acknowledgement was not obtained:_____

Staff Witness seeking acknowledgement

_____Date:_____

NOTICE OF ELECTION
FOR
OUT OF NETWORK BENEFITS

By his or her signature below, the undersigned patient/beneficiary (the "Patient/Beneficiary") states Patient/Beneficiary is aware that he or she has paid for a health insurance plan that includes out-of network benefits. It is the intention of the Patient/Beneficiary that this statement shall serve as official notification that Patient/Beneficiary has elected to the Patient/Beneficiary's out-of-network benefits as outlined in his or her health insurance plan and that the Patient/Beneficiary understands the implication of such election.

The Patient/Beneficiary understands that the hospital/provider he or she has selected, namely DEC ANESTHESIA LLC, is not participating in his/her health insurance plan's network.

The Patient/Beneficiary understands that the benefits received from his or her health insurance plan for the services provided by the Provider the Patient/Beneficiary has selected will be out-of network benefits, which are different than in-network benefits.

Should this election for out-of-network benefits (as stated above) be prohibited in part or in whole under any provision of Patient/Beneficiary's policy/plan, please advise and disclose in writing, within 30 days after your receipt of this selection by the Patient/Beneficiary, to his or her Provider and to the Patient/Beneficiary, the specific plan provision that prohibits Patient/Beneficiary from electing out-of network benefits; otherwise, this election should be reasonably expected to be effective.

If you do not wish to approve Patient/Beneficiary's claim as submitted, please promptly provide the necessary claim forms, instructions, reasonable assistance and documents including the Summary Plan Description, that were relied upon to make the decision so that the Patient/Beneficiary may comply with the policy conditions and the insurer's reasonable requirements.

PATIENT/BENEFICIARY

_____ Date_____
Signature

_____
Print Name

Patient Name_____ Date of Service_____

RSKM LLC understands the frustrations and challenges involved in navigating the insurance process, especially when benefits you are entitled to are denied. We wish to assist you by submitting an appeal on your behalf. If you would like us to submit an appeal on your behalf, please sign the form below giving us authority to act, as required under the terms of your health benefits coverage. Please note that this assignment of benefits authorizes RSKM to act on your behalf in submitting appeals to responsible parties involving all benefits and rights due under your plan for healthcare services rendered, including, but not limited to, receipt of all documents and information pertinent to the denial of claim. Additionally, RSKM will exercise all rights available, as needed, to request an administrative review in order to ensure your claim and all appeals were handled appropriately by the health insurance provider.

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ASSIGNMENT OF BENEFITS

I, _____ (Patient Name), hereby irrevocably designate, authorize and appoint RSKM LLC ("RSKM"), and/or its authorized agent, DEC ANESTHESIA LLC , as my true and lawful attorney-in-fact. This power of attorney is hereby provided for the specific and limited purpose of receiving all payments due under the insurance policy/medical care plan for healthcare services and medical care rendered or to be rendered. This power of attorney shall automatically terminate without formal action being taken as soon as my healthcare provider service has received payment in full and/or all remedies under applicable regulatory guidelines for all medical care services have been exercised. I hereby confirm and ratify all actions taken by my attorney-in-fact pursuant to the authority granted herein.

I hereby authorize my healthcare insurance provider to assign and transfer all applicable ERISA plan benefits and rights to DEC ANESTHESIA LLC or RSKM, a Business Associate of my healthcare provider service, to assure all rights and benefits under my plan are administered accurately, including the right to receive any applicable plan documents/remedies, disclosures, pursue appeals, administrative reviews and litigation on my behalf. This authorization includes any and all other rights permissible under state and federal laws, including the right for administrative review by the appropriate governing body.

I hereby instruct and direct my healthcare insurance provider to pay RSKM directly. I understand under applicable ERISA, state and/or federal regulatory guidelines that I have the right and authority to direct where payment for services rendered is sent. If my current policy prohibits direct payment to RSKM, I, under my rights in accordance with state and federal ERISA regulations, hereby instruct and direct my healthcare insurance provider to provide Summary Plan Description ("SPD") documentation stating such non-assign ability to me and to RSKM. Upon proof of such non-assign ability under the SPD, I instruct my healthcare insurance provider to make its check payable to me and mail it directly to the healthcare service provider at the address listed on its submitted claim for professional or medical expense benefits, such amount to be applied toward payment of all charges for professional healthcare services rendered to me by such healthcare provider. I hereby certify that the insurance information that I have provided RSKM LLC is true and accurate as of the Date of Service above, and further, I certify that I understand that I am responsible for keeping such information updated. I am aware that I am entitled to all benefits and rights due under my insurance policy/plan for healthcare services deemed to be medically necessary, as discussed between myself and my physician. I am also aware that having health insurance does not relieve me of my responsibility to ensure that bills for medical services are paid in full.

A photocopy of this Assignment of Benefits shall be considered as effective and valid as the original.

_____ Date_____

Signature of Patient/Guarantor

_____ Date_____

Signature of Witness