PICCARD SURGERY CENTER, LLC

ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE ANO /OR HEALTH BENEFIT PLAN (INCLUDING BRECH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED 11EPRESENTATIVE

I hereby assign and *convey* directly to the Piccard Surgery Center1LLC1 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 clalm or chose an action arising under any group health plan, employee benefits plan, health Insurance or tort feasor 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(Employee Retirement Income Security Act) breach or fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to 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 mediations 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 ,thls 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.

IHAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

AUTHOR IZATIONS & DISCLOSURES

These AUTHORIZATIONS MUST BE SIGNED BY THE PATIENT (or by the party legally responsible for a minor or physically or mentally incapacitated patient), and by the party financially responsible for the patient, if other than the patient. PLEASE READ EACH AUTHORIZATION CAREFULLY.

1. AUTHORIZATION FOR MEDICAL TREATMENT : Each of the undersigned hereby authorize

any anesthesia, medical or surgical treatment, and Piccard Surgery Center service rendered or provided under the general and special instructions of my attending physician, his/her assistants, and other practitioners associated for purposes and diagnosis, treatment and medical care. NO PROMISE, GUARANTEE OR WARRANTY HAS BEEN MADE

REGARDING THE RESULTS OF ANY MEDICAL TREATMENT OR SURGICAL PROCEDURE. Any and all removed organs, or parts may be disposed of in accordance with accepted medical practices

2. AUTHORIZATION TO RELEASE MEDICAL INFORMATION: For Purpose of reimbursement: Piccard Surgery Center and each attending or treating practitioner, including, if applicable, PATHOLOGY ,ANESTHESIA , and/or RADIOLOGIST, are hereby authorized and directed to disclose all or any part of the medical record for this admission to my employer,to my insurance companies, and other organizations, third party payers, or agencies as may be necessary to verify or process any and all claims for insurance coverage or third party reimbursement. WE UNDERSTAND THAT SUCH DISCLOSURES MAY CONTAIN INFORMATION WHICH COULD RESULT IN LIMITATION OR DENIAL OF INSURANCE BENEFITS OR THIRD PARTY REIMBURSEMENT OR WHICH COULD OTHERWISE BE HARMFUL OR PREJUDICIAL TO MY (OUR) INTERESTS. Nevertheless, each of the undersigned do hereby release and hold Piccard Surgery Center, its officers, directors, agents and employees, and all examining and treating practitioners harmless of and from any and all cost, loss, damage, or liability resulting from such disclosure(s).

3. ADVANCED RECEIPT OF DOCUMENTS: I acknowledge that I received notice of advanced directives and Consumer Bill of Rights and Responsibilities in my pre-op folder that I obtained from my surgeon's office prior to my date of service. It was also brought to my attention by the pre-op nurse during my phone interview. In the event that if I did not receive the documents prior to the procedure, I was given the documents at the time of my procedure with an opportunity to review them .

4. RELEASE OF RESPONSIBILITY FOR VALUABLES : Piccard Surgery Center is hereby fully released of and from any and all responsibility for loss or damage to the personal property, money, or valuables of the undersigned patient.

5. NOTICE OF PRIVACY PRACTICES : I am aware of my rights to privacy of personal health information, under the Privacy Rule of Health Insurance Portability and Accountability Act of 1996

("HIPAA"). Any breach in privacy of our records, WE will inform you. We have chosen to participate in the Chesapeake Regional Information System for our Patients, INC. This is a statewide health information exchange. You may "opt-out" and disable all access to your health information by completing and submitting an "opt-out" form to CRISP.

6. PHYSICIAN OWNERSHIP DISCLOSURE: Piccard Surgery Center provides services only to patients admitted by private practitioners who are members of the Piccard Surgery Center medical staff, some of whom retain joint ownership of the surgery center.