Transmed Inc.
The Ultrasound Professionals
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•AUTHORIZATION • ASSIGNMENT OF BENEFITS • ERISA AUTHORIZED REPRESENTATIVE FORM & • RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

Authorization to Perform Services

I hereby grant permission to the medical staff to perform simple and common procedures they deem necessary as ordered by my physician. I further understand that there are risks associated with simple and common procedures and that the healthcare provider cannot guarantee success.

Assignment of Insurance Benefits – Appointments 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, **Transmed, Inc.** and I appoint them as my authorized representative with the power to: **(1)** File medical claims with the health plan; **(2)** File appeals and grievances with the health plan; **(3)** Institute necessary litigation and/or complaints against my health plan naming me as plaintiff in such lawsuits and actions if necessary. **(4)** 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 **Transmed, Inc.** 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 **Transmed, Inc.** 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 **Transmed, Inc.** 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 **Transmed, Inc.** 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 as my Authorized Representative in connection with any claim, right, or cause of action including litigation against my health plan (even to name me as plaintiff in such action) that I may have under such insurance policy 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 receive from **Transmed, Inc.** 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. **(3)** I authorize communication with **Transmed, Inc.** and its 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 original.

I understand that Transmed, Inc. will protect the confidentiality of protected health information and will release my protected information only for the purpose stated above.

HIPAA Notice

I hereby acknowledge that I have been given a copy, or offered a copy of the HIPAA Notice of Privacy Practices.

_____ _____
Patient Signature (or Parent or Guardian) Date

_____ _____
Print name of Patient (and name of person signing) Relationship to patient