Dr. Raymond A. Semente

CHIROPRACTOR
265 LAKE AVENUE - ST. JAMES, NEW YORK 11780
Tel. 631 584-7722
Fax 631 584-6198

Assignment Of Benefits And Conditions For Treatment

CONSENT TO MEDICAL AND SURGICAL PROCEDURES AND PHOTOGRAPHS

The undersigned (hereinafter "Patient" which shall also include parents or legal guardians if the Patient is a minor or lacks legal capacity and representatives of the Patient), consents to the procedures and services that may be performed by Dr. Raymond A. Semente D.C., P.C. (hereinafter referred to as the "Provider"). I consent to the taking of pictures of my medical or surgical condition or treatment, and the use of the pictures and medical history and/or medical records for purposes of my diagnosis or treatment or for education or training programs conducted by the Provider. I understand that I have the right to request the cessation of recording or filming.

PERSONAL BELONGINGS

It is understood and agreed that the Provider shall not be liable for the loss or damage to any money, jewelry, documents, furs, fur coats and fur garments or other articles of unusual value or of any value.

PATIENT PERSONAL HEATH INFORMATION

The Patient agrees and provides consent to the Provider to discuss and disclose his/her personal health and medical information ("PHI") with any of its staff, its representatives and third parties for purposes of treatment, payment of services or operations. Specifically, the Provider may release Patient PHI to The Patriot Group and The Force Law Firm PC for the purpose of obtaining reimbursement of services provided to the Patient by the Provider. It is understood that there exists a Business Associates Agreement between the Provider and The Patriot Group and The Force Law Firm PC. In addition; I specifically authorize The Patriot Group and The Force Law Firm PC to communicate with my Health Insurer, Health Care Plan and any assigned administrator of the Plan, or any regulatory authority about medical claims for services performed upon Patient by the Provider (hereinafter, "Patient Medical Claims"). In addition, I specifically authorize The Patriot Group and The Force Law Firm PC to discuss or disclose any Patient PHI relating to Patient's Medical Claims to my Health Insurer, Health Care Plan, any assigned administrator of the Plan or any reguletory authority.

AUTHORIZATION TO FILE CLAIMS AND APPEALS

The Patient agrees and provides consent for the Provider, its staff, The Patriot Group and The Force Law Firm PC, to do the following on my behalf: (1) file Patient Medical Claims with my Health Plan; and (2) file any necessary appeals of denied or partially paid Patient Medical Claims with my Plan or regulatory authorities on my behalf; and
(3) file any necessary external appeals with regulatory authorities; and (4) file litigation if necessary to get

Patient's Medical Claims paid; and (5) name Patient as a plaintiff in such lawsuit if litigation is necessary to get Patient's Medical Claims paid; and (6) to obtain a complete copy of my Health Plan, Health Policy and Summary Plan Description; and (7) to obtain any medical records or reports of the Patient including HIV and psychological records needed to obtain reimbursement of the Patient's Medical Claims.

FINANCIAL AGREEMENT

The Patient agrees, whether he/she signs as agent or as Patient, that in consideration of the services to be rendered to the Patient, he/she hereby individually obligates him/herself to pay the account of the Provider in accordance with the regular rates and terms of the Provider, should the account be referred to an attorney or collection agency for collection, the Patient agrees to pay actual attorneys' fees and collection expenses plus interest at 10% annum. The Patient, his/her agent or representative, understand that medical bill submission to the Patient's Health Plan is done by the Provider's billing staff or authorized representatives as an accommodation to the Patient; that this does not in any way diminish or eliminate the Patient or his/her agent or representatives obligation to pay their account in full after services are rendered by the Provider.

ASSIGNMENT OF INSURANCE BENEFITS

The Patient authorizes, whether he/she signs as agent or as Patient, and assigns and directs payment to the Provider of any insurance benefits otherwise payable to or on behalf of the Patient for the seivices provided by the Provider. It is agreed that payment to the Provider, pursuant to this authorization, by an insurance company (or an administrator or sponsor of a self funded health plan) shall not discharge said insurance company (or an administrator or sponsor of a self-funded health plan) or the Patient of any and all obligations under a policy or Health Plan and the Patient shall remain responsible for full payment of the Provider's charges to include deductibles and coinsurance. It is understood by the Patient that he/she is financially responsible for Provider's charges not paid pursuant to this assignment. If the Patient or his/her agent or representative receives a check from their insurance company (or an administrator or sponsor of a self-funded health plan), the Patient or its agent or representative agrees to immediately and without delay send that check to the Provider after endorsing it as payable to the Provider, "For Deposit Only". The Patient understands that the Provider is compensating The Patriot Group, The Force Law Firm PC and any other representatives retained by the-Provider. The Patient is not being held responsible for payment of any compensation to these Provider representatives. The Patient assigns any and all causes of action either in Patient's name or the Provider's name. This is an act of assignment of Patient's rights and benefits to the Provider for services provided to Patient by Provider.

OUT-OF-NETWORK STATUS OF PROVIDER

The Patient understands that the Provider is Out-of-Network ("OON") with some insurance company and self-funded health plans meaning that Provider may not participate in Patient's Health Plan's Managed Care Network. Patient understands that, as a result of Provider's OON status with such plans, that Patient is responsible for the Provider's charges after payment of any collectable Health Plan payment, Provider and its representatives will appeal any denied, or partially paid Patient Medical claims. However, Patient is responsible for payment of any OON deductible and OON coinsurance upfront before services are rendered by the Provider. The Patient understands that provider may not waive or reduce any coinsurance, deductible or Patient responsibility except for financial hardship as set forth in the Provider's Charity Care Policy.

CHARITY CARE POLICY

The Patient acknowledges that he/she received the Provider's Charity Care Policy. If a Patient believes that he/she qualifies for a partial or total reduction of patient responsibility, coinsurance or deductible under such policy, the Patient must notify the Provider in writing and provide a copy of his/her Federal Income Tax Return for the tax year prior to the year services were rendered.

HEALTH PLAN OBLIGATIONS

The Provider maintains a list of Health Plans with which it contracts. A list of such plans is available upon request from the Provider's billing staff. The Provider has no contract, express or implied, with any plan that does not appear on the list. The Patient agrees that he/she is individually obligated to pay the full charges of all services rendered to him/her by the Provider regardless of whether or not the Provider is in-network or not with any such Health Plan.

CONSENT TO COMMUNICATION BY MAIL, EMAIL AND PHONE CALL

The Patient and his/her agent or representative hereby voluntarily provide their address, email and cell telephone number to the Provider and its authorized representatives The Patiiot Group and The Force Law Firm PC. The Patient and his/her agent or representative hereby authorizes the Provider and its authorized representatives The Patriot Group and The Force Law Firm PC to send and otherwise communicate with Patient or his/her agent or representative by email, mail and phone call with respect to the Patient's Medical Claims. The Patient and his/her agent or representative hereby voluntarily consent to such communication as required by 15 USC 7001 and related state regulations and statutes. The Patient and his/her agent or representative may provide written notice to the Provider or its authorized representative The Patriot Group and The Force Law Firm PC to receive any communication by email or on paper or non-electronic form. The Patient and his/her agent or representative agrees that his/her consent is continuous. However, the Patient and his/her agent or representative may terminate this consent in writing to the Provider or their authorized representative The Patriot Group and The Force Law Finn PC . The Provider and its authorized representatives The Patriot Group and The Force Law Firm PC agree that it will not sell, share, or rent patient addresses, phone numbers, emails or any other personal information collected based upon this consent. My address is _____ , my email address is _____ and my telephone number is _____.

PATIENT ACKNOWLEDGEMENT

I _____ (print patient's name), hereby acknowledge that at the beginning of my Treatment or services rendered by the Provider, I have been furnished with the Provider's Charity Care Policy and this Conditions to Treatment document, I voluntarily sign this acknowledgement that I consent and agree to the Conditions of Treatment for services to be rendered by the Provider.

Signed by: _____(The Patient)

Acknowledged on: _____(Date)

PATIENT's PARENT, LEGAL GUARDIAN OR REPRESENTATIVE ACKNOWLEDGEMENT

I,_____(print name), am the parent, legal guardian or representative, for the Patient.

I hereby acknowledge that at the beginning of the Treatment or services rendered by the Provider, I have been furnished with the Provider's Charity Care Policy and this Conditions to Treatment document. I voluntarily sign this acknowledgement and agree to the Conditions of Treatment for services to be rendered by the Provider.

Signed by: _____

(The Patient's Parent, Legal Guardian, or Representative)

Acknowledged on:_____(Date)