ARIA HEALTH GROUP **Assignment of Benefits**

This form authorizes ARIA HEALTH GROUP to pursue any and all claims for insurance benefits directly from your insurance provider in your place. Please note that in the event that your insurance company or benefit plan does not pay, you are still responsible for all charges. ARIA HEALTH GROUP is under no obligation to pursue your insurance company or benefit provider for payment.

I, _____, hereby assign and convey directly to ARIA HEALTH GROUP, as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, and therapies provided by ARIA HEALTH GROUP, 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 ARIA HEALTH GROUP 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 ARIA HEALTH GROUP any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from ARIA HEALTH GROUP 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 ARIA HEALTH GROUP, any legal or administrative claim or chose an action arising under any group health plan, employee benefits plan, health insurance or tort insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from ARIA HEALTH GROUP (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach, fiduciary duty claims, bad faith, and other legal and/or administrative claims. I intend by this assignment and designation of authorized representative to convey to ARIA HEALTH GROUP, 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 ARIA HEALTH GROUP, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). I give the assignee and/or designated representative (ARIA HEALTH GROUP) the authority 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.

ARIA HEALTH GROUP 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, this 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.

I acknowledge that this form authorizes ARIA HEALTH GROUP to disclose my protected health to my insurance company, benefit provider or plan, for the purpose of obtaining payment for services provided to me or pursuing any claim authorized by this form. This authorization to disclose protected information will expire after all outstanding balances owed to ARIA HEALTH GROUP have been settled in full. I have read and fully understand this agreement. I understand that I am assigning my rights to

ARIA HEALTH GROUP

ARIA HEALTH GROUP to pursue claims on my behalf and that I am ultimately responsible for all charges.

Patient Signature _____ Date _____