PATIENT FINANCIAL RESPONSIBILITY, ASSIGNMENT OF BENEFITS, AND AUTHORIZED REPRESENTATIVE AGREEMENT

In return for the services I receive and/or have received from OakLeaf Clinics Inc. ("**Provider**"), I agree to:

1. **Assignment of Benefits.** As a participant, beneficiary, or insured, I hereby irrevocably assign and transfer to Provider for application only to my medical bill for services, all of my rights, benefits, and claims (including but not limited to those arising under ERISA) for reimbursement under any federal or state healthcare plan or program (including but not limited to Medicare and Medicaid), insurance policy, managed care arrangement, self-funded or other benefit plan, or other similar third party arrangement that covers health care costs for which payment may be available to cover the cost of the services provided to me by Provider (collectively, "**My Coverage**"). These assigned and transferred rights include, but are not limited to:

   a) The right to receive payment for any medical bills incurred as a result of services provided by Provider;
   b) The right to obtain information about My Coverage, including but not limited to information about plan features and funding;
   c) The right to appeal any adverse benefit determination or other denial;
   d) The right to bring fiduciary duty claims or seek declaratory or injunctive relief or penalties on my behalf;
   e) The right to submit any dispute in my name to binding arbitration.

   I permit a copy of this Agreement to be used in place of the original for the purpose of obtaining payment under My Coverage. To the extent my rights are alleged to be non-assignable, and in addition to my appointment of an authorized representative below, I retain the right to payment but direct and authorize My Coverage to send any reimbursement check, payable to me, directly to Provider. I understand that despite any benefits ultimately received by Provider as a result of this assignment, I am financially responsible to Provider for any charges not paid, in whole or in part, by My Coverage, including but not limited to co-payments, deductibles, co-insurance, and non-covered services under My Coverage.

   Attention Plan Administrators and Insurance Carriers: This is a direct assignment of my rights and benefits under My Coverage which is your plan or policy. If applicable under My Coverage, I hereby request your consent to the form and content of this Agreement, and the resulting legal rights assigned and transferred to Provider. Your failure to withhold or deny your approval on reasonable grounds within 72 hours of receipt of this request shall constitute your approval of this Agreement.

2. **Limited Power of Attorney and Appointment of Authorized Representative**. In the event My Coverage does not accept my assignment, or My Coverage prohibits my assignment of certain or all rights or benefits, or my assignment is otherwise challenged or deemed invalid, I execute this limited power of attorney and irrevocably designate, authorize, and appoint Provider and Provider's attorney (collectively, "**My Representative**") as my agent, personal and authorized representative, and attorney for the limited purpose of collecting payment for Provider's services directly against My Coverage, in my name, including but not limited to administrative and other appeals and arbitration/litigation. I specifically authorize My Representative to file directly against My Coverage in my name or in Provider's name as a medical provider rendering services to me, and designate My Representative as my personal and authorized representative and attorney in fact.

   I further grant a limited power of attorney to Provider as my medical provider to receive and collect directly from My Coverage any and all money due Provider for services rendered to me, and instruct My Coverage to pay Provider directly any monies due Provider for medical services that Provider provided to me. I further authorize My Representative to receive from My Coverage, immediately upon request, all information regarding payment(s) made by My Coverage on my claim(s), including date(s) of payment(s) and balance(s) of benefits remaining. I also agree that any fines, interest, attorney fees, or other awarded damages that may be levied against My Coverage will be paid to Provider when acting as My Representative.

   This limited power of attorney shall automatically terminate, without formal action being taken, as soon as Provider has received payment in full and the remedies available under applicable statutory and regulatory guidelines for the medical care services that Provider provided to me. I hereby confirm and ratify all actions taken by My Representative pursuant to the authority granted in this Agreement.

3. **Cooperation.** I agree to cooperate with Provider to pursue all available remedies, benefits, and payment. I agree to fulfill any reasonable request from Provider such as signing correspondence or obtaining information about My Coverage from my employer or insurer. I agree that no guarantees have been made to me as to the results of examinations or treatments provided to me by Provider.

4. **Insurance, Health Benefits Coverage, and/or Medical Assistance**. **It is my responsibility to provide Provider with current and accurate My Coverage and/or medical assistance program(s) information at the time of service**. I certify that the information given by me in applying for payment under My Coverage and/or medical assistance program(s) is correct. I authorize Provider to release any information about me which is properly needed for processing and paying My Coverage and/or medical assistance program(s) claims.

5. **Responsibility for Payment.** I understand that am responsible for all amounts not otherwise paid, in whole or in part, by My Coverage, including but not limited to **co-payments, deductibles, co-insurance,** and **non-covered services** under My

Coverage. I agree to pay for all charges that are due because of my care and treatment by Provider in accordance with Provider's regular charge-master rates and terms. I agree to pay any applicable co-payments at the time of service. I also understand that I am responsible for paying Provider in full for services My Coverage will not cover due to non-payment of any premiums required under My Coverage. I understand that although Provider may file claims with My Coverage as a courtesy to me, I am ultimately responsible to pay for the services received.

6. **No Show and Cancellation Policy.** I understand that Provider requires 24-hour notice if I am unable to keep a previously scheduled appointment. In the event I do not provide 24 hour notice or do not show up for my appointment, Provider reserves the right to charge a $25 fee to your account.

7. **Returned Checks.** I understand that if any check payment is returned due to NSF (non-sufficient funds) or a cancelled check, I will be charged a $35 NSF fee. This fee, as well as the account balance, is due upon receipt. Provider will reserve the right to only accept payment in the future for my account with cash, credit or debit cards.

8. **Payment Plan Options.** I understand that if I have an outstanding balance as the result of Deductibles, Co-Insurance, or self-pay, I have the option to work with Provider to set up a mutually agreeable payment plan approved by Provider. Provider will not waive, fail to collect, or discount co-payments, co-insurance, deductibles or other patient financial responsibility in accordance with State and Federal law, as well as participating agreements with payers. I understand that future services may be denied if my account is not current or I have failed to make payment arrangements on my account. I also understand that I may be asked for payment for services in advance. Additional payment options may be available through Provider's Payment Assistance Program.

9. **Self-Pay Accounts.** Self-pay accounts are patients without insurance coverage, patients unable to present a valid member identification card from your health insurance carrier or if Provider is not able to verify active health insurance coverage. Self-pay patients may be eligible for a 15% discount. Payment is expected in full at the time of service. Any self-pay balances remaining will be my financial responsibility. Failure to pay my self-pay balance may result in removal of discount.

   I agree to pay all amounts due within the time period described in my billing statement(s). It is my responsibility to contact Provider's billing department to make payment arrangements for all balances not paid in full within the time period described in my billing statement(s). I authorize Provider to transmit billing statements to me electronically. In the event I have not made arrangements for payment and my account is placed with an attorney or collection agency, I am responsible for collection fees, attorneys' fees and court costs. I hereby provide Provider and its representatives and business associates (including third party debt

collectors) my permission to contact me for any purpose associated with my account, including via wireless telephone numbers. I understand that this may include the use of automated dialing equipment, prerecorded voice, or text messages.

I certify that I have read this Agreement, had the opportunity to ask questions about it, and understand its contents. If the patient is a minor, I attest that he/she is a beneficiary under My Coverage and that I sign as a parent/guardian and as the person financially responsible for payment for any medical bills. I agree that this Agreement constitutes the sole and entire agreement between me and Provider regarding the subject matter of this Agreement, and it replaces all prior understandings or agreements regarding such subject matter.

Signature of Patient or Parent/Guardian	Date
Print Patient's Name	Date
Provider Witness to the Above Signature	