Primero Med

CONSENT TO TREAT

I hereby authorize employees / agents of Primero Med, LLC (including physicians, physician assistants, nurse practitioners, and other employees /staff members) to render medical evaluations and care to the patient indicated below. I understand if the patient is a minor that this consent authorizes the foregoing person(s) to consent to medical and surgical procedures. The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in the case of medical emergency.

_____	_____	_____
PATIENT NAME (PLEASE PRINT)	SIGNATURE OF PATIENT / LEGAL GUARDIAN	DATE

LEGAL ASSIGNMENT OF BENEFITS AND DESIGNATION OF AUTHORIZED REPRESENTATIVE, AUTHORIZATION FOR RELEASE OF MEDICAL AND SUMMARY PLAN DOCUMENTS OF THE HEALTH PLAN FOR PROCESSING & REIMBURSEMENT AS REQUIRED BY FEDERAL AND STATE LAWS

For the medical expenses incurred, I have insurance and/or employee healthcare benefits coverage captioned in the provider's New Employee Registration Form. I hereby assign the above named healthcare provider(s) as my designated Authorized Representative(s) and transfer directly all medical benefits and / or insurance reimbursement, if any, otherwise payable to me for services rendered by this provider and regardless of provider network participation. I understand and agree that I am legally responsible for any and all total charges regardless of any applicable insurance or benefit payments.

I hereby authorize the above named provider(s) to release all medical information necessary to process my claims under HIPAA. I authorize any plan administrator or fiduciary, insurer and my attorney to release to this provider any and all plan documents including Summary Plan Description and Master Plan Description, health plan policy and / or claim settlement information upon written request from such provider for the purpose of claiming such medical benefits, reimbursement, or any applicable remedies. I authorize the use of this signature on all my insurance and / or employee health benefit claim submissions.

I hereby transfer to the above named provider(s), to the full extent permissible under the laws, including but not limited to, ERISA §502(a)(1)(B) and §502(a)(3), under any applicable employee group health plan(s), insurance policies or public policies, any benefit claim, liability or tort claim, chose in action, appropriate equitable relief, surcharge remedy or other right I may have to such group health plans, health insurance issuers or tort feasor insurer(s), with respect to any and all medical charges legally incurred as a result of the medical services received from the above named provider(s), and to the full extent permissible under the laws to claim or lien such medical benefits, settlement, insurance reimbursement and any applicable remedies, including, but are not limited to:

(1) obtaining information about the claim to the same extent as the assignor;
(2) submitting evidence;
(3) making statements about facts or law;
(4) making any request, or giving, or receiving any notice about appeal proceedings; and
(5) any administrative and judicial actions by such provider(s) to pursue such claim, chose in action or right against any liable party or employee group health plan(s), including, if necessary, bring suit by such provider(s) against any such liable party or employee group health plan in my name with derivative standing but at such provider(s) expenses.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal or state laws. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

_____	_____	_____
PATIENT NAME (PLEASE PRINT)	SIGNATURE OF PATIENT / LEGAL GUARDIAN	DATE