WEBSTER OUTPATIENT SURGERY CENTER
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Insurance Coverage & Assignment of Benefits

We at _Webster Outpatient Surgery Center_ ("Provider") believe that providing our patients with the best, most advanced surgical care in a positive and supportive environment ("Services") includes helping our patients clearly understand their financial rights and responsibilities with regards to the services they receive from us. This document will outline how your insurance will be used to cover the costs related to Services we provide to you and give us, your Provider, some important tools for the billing process.

The rules of health insurance coverage and reimbursements are often confusing to even the most experienced patients. When it comes to covering the cost of a surgery, dealing with health insurance can often be a lengthy and complex process. By providing us with all the necessary acknowledgements and authorizations ahead of time, you enable us to effectively and efficiently bill your insurance while minimizing your own out-of-pocket expenses. Additionally, with your permission, we can make faster and more successful appeals to the insurance company on their behalf if needed.

Please carefully read and complete the following:

1. I am a participant, beneficiary, subscriber, or enrollee of a health insurance policy or plan ("my Insurance"), which includes all types and sources of insurance coverage applicable to my specific situation.

2. My insurance is provided by: ☐ myself ☐ my employer ☐ employer of my spouse or guardian, _____ (name of employer)

3. My insurance is administered, issued, and/or insured by _____ (insurance company name)

    - Subscriber Name: _____ Subscriber Date of Birth: _____

4. It is my intention to have any benefits owed to me by my Insurance paid directly to my Provider, and to give Provider the right to bring -- on my behalf--all legal claims that I have against my Insurance and/or its fiduciaries relating in any way to benefits that are owed to me for Services rendered to me by Provider.

5. It is also my intention to transfer, give, and assign my benefits under my Insurance to Provider to the extent needed for the transfer of rights and powers outlined below.

Accordingly:

A. *PATIENT ACKNOWLEDGEMENT OF OWNERSHIP

I understand and acknowledge that Provider is a surgeon-owned facility.

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B. PATIENT ACKNOWLEDGEMENT OF FACILITY'S NETWORK STATUS

Initial One	
_____	☐ I understand and acknowledge that Provider is "**In Network**" (has a contract with my Insurance) and is bound to accept payment amounts pre-negotiated by my Insurance, including copayment, deductible, and coinsurance amounts as governed by my Insurance plan.
_____	☐ I understand and acknowledge that Provider is "Out of Network" (does not have a contract with my Insurance) and that I may be responsible for a higher share of the costs relating to the Services than if I went to a surgery center within the network of my Insurance.

C. *PATIENT ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITIES

I understand and acknowledge that I am liable for the full charges as governed by my Insurance plan, and as permitted by law, for Services that I receive from Provider and agree to pay all such charges that are not paid by my Insurance. I understand I am also responsible for paying my copayment, deductible, and coinsurance.

I further understand that my Insurance may send payment(s) relating to the Services directly to me or to the policyholder, and I agree to forward all these payments to Provider within five (5) business days of receipt.

It is my intent for my Insurance benefits to cover some or all of the cost related to Services I am receiving from Provider. In order for Provider to best assist me in accessing my Insurance benefits, I hereby execute the following authorization, designations, and/or assignments:

D. *AUTHORIZATION FOR PROVIDER TO RELEASE AND RECEIVE MY HEALTH INFORMATION

I authorize Provider to release and receive my protected health information (PHI), in accordance with State and Federal regulations, both from and to my Insurance, my employer, my physicians and/or other necessary parties, for pursuing payment of a claim for insurance benefits ("Benefit Claim").

E. *AUTHORIZATION FOR PROVIDER TO RECEIVE MY HEALTH PLAN DOCUMENTS

I authorize Provider to request and further authorize my Insurance and/or its fiduciaries to release a copy of my Insurance plan, Summary Plan Description, and other related plan/policy documents describing my benefits.

F. *AUTHORIZATION TO COMMUNICATE BY EMAIL

I authorize Provider and/or its agents to communicate with me via email and that I am authorized to communicate via email with Provider and/or its agents.

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G. AUTHORIZATION FOR PROVIDER TO RECEIVE MY BENEFIT PAYMENTS

I authorize Provider to submit Benefit Claim(s) directly to my Insurance and/or its fiduciaries, and I authorize and direct my Insurance and/or its fiduciaries to pay such benefits directly to Provider. I hereby designate Provider as the party entitled to such benefits, pursuant to ERISA, 29 U.S.C. § 1002(8) where applicable.

H. AUTHORIZATION FOR PROVIDER TO APPEAL ON MY BEHALF

Should any dispute arise between Provider and my Insurance and/or its fiduciaries relating to a Benefit Claim, it is my intention that my Insurance and/or its fiduciaries give Provider on my behalf any and all rights to which I would otherwise be entitled. I therefore appoint Provider as my true and lawful attorney-in-fact for the purpose of exercising the following powers on my behalf:

1. To act in any way necessary to pursue payment of a Benefit Claim under my Insurance, including but not limited to, administrative appeals;

2. To act in any way necessary to investigate, file, pursue, and resolve litigation on my behalf (including but not limited to selecting and retaining legal counsel) of all legal and equitable claims that I could bring against my Insurance and/or its fiduciaries. Such legal and equitable claims shall include, but not be limited to, any and all claims (including breach of fiduciary duty claims) that I could bring pursuant to ERISA, 29 U.S.C. § § 1132(a)(1), (a)(2) or (a)(3), or other provisions of ERISA that grant me a cause of action, where applicable; other federal or state statutes; or the common law, and shall include class claims in which Provider serves as a class representative (hereinafter, collectively, "Causes of Action"). If Provider brings such an action, I agree to be bound by a final determination of such action rendered by a court or regulatory proceeding.

3. To sign on my behalf settlement agreements, releases, or other documents relating to the settlement of the Causes of Action. I hereby agree to be bound by any settlement, compromise or release reached by Provider on my behalf and that any document executed in connection with any such settlement, compromise or release by Provider on my behalf shall be binding on me.

4. To claim on my behalf any benefits, reimbursements, damages, surcharges, or any other applicable remedy, including fines or injunctive relief, to which I am entitled in connection with the Causes of Action.

5. I hereby confirm and approve all actions taken by my Provider pursuant to the authority granted herein.

I. DESIGNATION OF AUTHORIZED REPRESENTATIVE

To the extent the authorization described in Section H above is deemed ineffective for any reason, I hereby designate Provider as my Authorized Representative as provided under ERISA, 29 C.F.R. § 2560.503-1(b)(4), where applicable, for purposes of exercising the powers described in Section H or authorized under law, whichever powers are greater.

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J. *ASSIGNMENT OF BENEFITS AND LEGAL RIGHTS

To the extent or in the event that any power(s) and/or rights conveyed by Sections D, E, F, G, H, and I are deemed ineffective or limited for any reason or in any way, I hereby transfer, give, assign, and otherwise convey to Provider, in exchange for receiving Services, the receipt and sufficiency of which are hereby expressly acknowledged: (a) all of my right, title, and interest in benefits under my Insurance for the Services I received, and (b) all legal and equitable rights that I have as a participant, beneficiary, subscriber or enrollee, including but not limited to all rights to: (i) submit a Benefit Claim directly to my Insurance and/or its fiduciaries; (ii) receive all benefits otherwise due me under my Insurance for Services; and (iii) bring any Cause of Action against my Insurance or any of its fiduciaries to obtain such benefits, to enforce the fiduciary duties owed to me by my Insurance and/or its fiduciaries, or to obtain any other appropriate legal or equitable relief available under the Cause of Action.

K. *MISCELLANEOUS

By signing this form, I understand that Provider is not assuming any obligation or duty to assert the rights conveyed in this document. I agree to release any claim I might have relating to Provider's exercise of such rights or the decision not to exercise such rights.

If Provider initiates a lawsuit against me to collect any unpaid balance owed for Services provided to me, all the rights and powers conveyed herein shall be rescinded and I retain any claims or defenses I otherwise may have against Provider.

A photocopy of this Agreement shall be as effective and valid as the original.

I certify that I have read and understand the above statements, that all my questions have been answered to my satisfaction, and that I agree with each statement above.

_____ _____

Patient /Parent/Guardian Insurance Identification Number

_____ _____

Signature Date