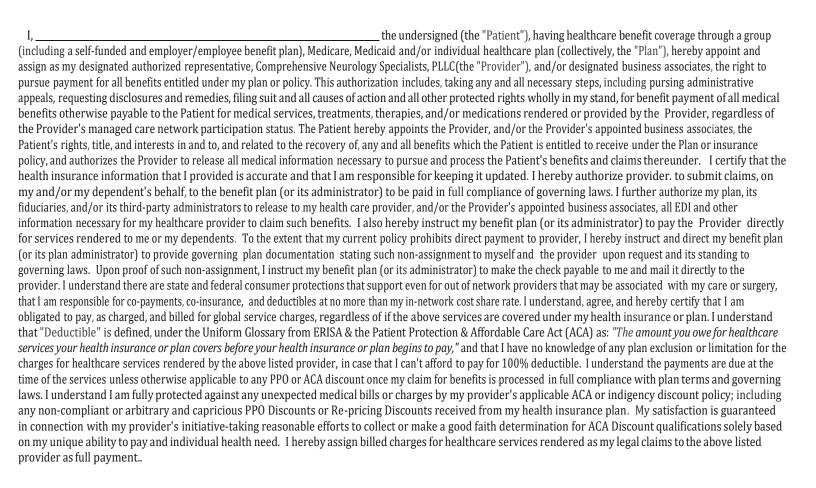




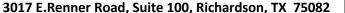
Comprehensive Neurology Specialists, PLLC



I hereby designate, authorize and appoint the Provider, it's attorneys or other designated business associate as my authorized representative to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; (3) To file and participate in any administrative or judicial review process; (4) to give the provider and its attorneys standing to pursue payment and file suit for benefits and any fiduciary breach and all causes of action available under ERISA and Section 502, 27 § U.S.C. 1132(a). (5) to pursue all necessary benefit payments, appeal rights, remedies and all causes of action, wholly in my stead; (6) to pursue a claim for benefits and to recover all applicable penalties for any fiduciary breach or failure by my plan, its fiduciary and/or its claims administrator to comply with 29 USC § 1132 and (7) allow a photocopy of my signature to be used to process insurance claims. This authorization will remain in effect until all benefits are paid in full compliance with applicable federal and state laws.

I hereby confirm and ratify all actions taken by my authorized representative pursuant to the authority granted herein. I hereby authorize my plan administrator, fiduciary, insurer, and/or attorney to release to the above-named health care provider or its designated business associated any and all relevant Plan and claim related documents, requested disclosures, complete insurance policy, and/or settlement information upon written request from the provider, its attorneys or designated







Phone# 469-902-9878



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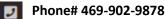


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business associates in order to secure and claim such medical benefits due and owed me under my plan or policy. I authorize the release or disclosure of my protected health information to my authorized representative in order to secure and claim medical benefits due; (1) obtain information or submit evidence regarding the claim to the same extent as me; (2) make statements about facts or law; (3) act as my authorized representative in connection with filing, providing or receiving notice of any claim or appeal proceedings, to include any external review by applicable state or Federal External Review Process. I understand that I will be held financially responsible for all fees accumulated for collection agency fees. Administrative fees, attorney fees and court costs incurred by the provider listed above for any delinquent account requiring outside collection assistance, to the fullest extent of the law. This order will remain in effect until revoked by me in writing. I understand revocation of this appointment will not affect any action taken in reliance on this appointment before my written notice of revocation is received. Unless revoked in writing, this assignment is valid for any and all requested administrative and judicial reviews rightfully due me under my governing plan or policy and to the fullest extent permitted by law. A photocopy of this assignment is to be considered valid, the same as if it were the original. I understand that, by signing this form, I am confirming my appointment of my designated authorized representative, the scope of my authorized representative's authority, and the option of revocation of this appointment. I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

Patient/Guardian/Insured Signature:	Date:	
Employer Group Name Covering Benefits:		







Fax#469-638-8399





