Assignment of Benefits Form
Wade & Associates/Family Health & Wellness, Inc

I _____ (Print Name) hereby authorize benefits to be assigned to Wade & Associates/Family Health & Wellness, Inc, for healthcare services provided to me by Wade & Associates/Family Health & Wellness, Inc. I hereby certify that the insurance information that I have provided Wade & Associates/Family Health & Wellness, Inc is true and accurate as of the date of service and that I am responsible for keeping it updated. I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my medical bill is paid in full. I also understand that my insurance company may not pay 100% of the amount of the medical claim and I may be responsible for any and all amounts not payable by my insurance company including any portion paid and not applied to in network benefits for any out of network services.

I hereby authorize Wade & Associates/Family Health & Wellness, Inc to submit claims, on my behalf, to the insurance company listed on the copy of the current insurance card I have provided Wade & Associates/Family Health & Wellness, Inc, in good faith. I fully agree and understand that the submission of a claim does not absolve me of my responsibility to ensure the claim is paid in full.

I hereby irrevocably, designate, authorize and appoint Wade & Associates/Family Health & Wellness, Inc as my true and lawful attorney-in-fact. This power of attorney is hereby provided for the limited purpose of receiving all payments due under my policy/medical care plan on account of medical services and care rendered or to be rendered. This power of attorney shall automatically terminate, without formal action being taken, as soon as Wade & Associates/Family Health & Wellness, Inc has received payment in full and remedies under applicable regulatory guidelines for all medical care services provided to patient. I hereby confirm and ratify all actions taken by my attorney-in-fact pursuant to the authority granted herein. I hereby authorize my insurer to assign and transfer any applicable ERISA plan benefits and rights to Wade & Associates/Family Health & Wellness, Inc including the right to receive any applicable plan documents/remedies, pursue appeals and litigation on my behalf. This authorization includes any other rights due me permissible under state and federal laws.

I hereby instruct and direct my Insurance Company to pay Wade & Associates/Family Health & Wellness, Inc directly. I understand under ERISA that I have the right and authority to direct where payment for services rendered is sent. If my current policy prohibits direct payment to the provider of service, I under my rights per state and federal ERSIA regulations hereby instruct and direct my Insurance Company to provide SPD documentation stating such non-assign ability clause to myself and Wade & Associates/Family Health & Wellness, Inc Upon proof of non-assign ability documentation I hereby instruct that the insurer make out the check to me and mail it directly to:

Wade & Associates
Family Health & Wellness, Inc
620 Quintard Dr, Suite 201
Oxford, AL 36203

for the professional or medical expense benefits, and otherwise payable to me under my current insurance policy as payment towards the total charges for the professional services rendered.

I agree and understand that any funds I receive by my insurance company due for services rendered by Wade & Associates/Family Health & Wellness, Inc will be immediately signed over and sent directly to Wade & Associates/Family Health & Wellness, Inc.

This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. Upon receipt of said check, I authorize Wade & Associates/Family Health & Wellness, Inc to receive any such checks, endorse them for deposit only, and to deposit and apply all the proceeds toward payment on my account.

I authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. I authorize Family Health & Wellness, Inc to be my personal representative, which allows Wade & Associates/Family Health & Wellness, Inc to: (1) submit any and all appeals when my insurance company denies me benefits to which I am entitled, (2) submit any and all requests for benefit information from my insurance company, and (3) initiate formal complaints to any State or Federal agency that has jurisdiction over my benefits. I fully understand and agree that I am responsible for full payment of the medical debt if my insurance company has refused to pay 100% of my benefits based on billed charges, within ninety (90) days of any and all appeals or request for information. Should the account be referred to an attorney or outside agency for collection, the undersigned shall pay reasonable attorney's fees and collection expenses. All delinquent accounts bear interest at the legal rate. I also agree that any fines levied against my insurance company will be paid to Wade & Associates/Family Health & Wellness, Inc for acting as my personal representative.

I authorize Wade & Associates/Family Health & Wellness, Inc and its associates to provide medical care reasonable by today's standards. A photocopy of this Assignment shall be considered as effective and valid as the original.

_____ _____
Signature of Patient/Guarantor Date

_____ _____
Signature of Policy Holder Date

Witness