Fellowship Surgical Center LLC
715A Fellowship Road
Mt. Laurel, NJ 08054

ERISA AUTHORIZED REPRESENTATIVE FORM

I hereby designate, authorize, and convey to Fellowship Surgical Center, LLC to the fullest extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (1) the right and ability to act as my Authorized Representative in connection with any claim, right, or cause of action including litigation against my health plan (even to name me as a plaintiff in such action) that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act as my Authorized Representative to pursue such claim, right or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to the right and ability to act as my Authorized Representative with respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. §2560.503-1(b)(4) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement and any other applicable remedy, including fines. I authorize communication with the Provider and his authorized representatives to obtain all relevant information on my behalf including but not limited to the summary plan description. I understand I can revoke this authorization in writing at any time. I direct all reimbursable medical payments go directly to you, my medical provider. In the event the Insurance carrier responsible for making medical payments in this matter does not accept my assignment, or my assignment is challenged or deemed invalid, I execute this limited/special power of attorney and appoint and authorize your collection attorney as my agent and attorney to collect payment for your medical services directly against the carrier in this case, in my name, including filing an arbitration demand or lawsuit. I specifically authorize that attorney to file directly against that carrier in my name or in your name as a medical provider rendering services to me and designate your attorney as my attorney in fact. I further grant limited power of attorney to you as my medical provider to receive and collect directly from the insurance carrier money due you for services rendered to me in this matter, and hereby instruct the Insurance carrier to pay you directly and monies due you for medical services you rendered to me. I authorize you and or your attorney to receive from my Insurer, immediately upon verbal request, all information regarding last payment made by said insurer on my claim, including date of payment and balance of benefits remaining as well as all other relevant documentation including but not limited to the summary plan description.

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

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Patient Date