ASSIGNMENT OF BENEFITS

I agree to pay Infinity Family Clinic for all charges and expenses incurred. I understand and agree that I am responsible for the total charges for services rendered. Regardless of any assignment of benefits provided. I further agree that the amounts charges are due upon request and are the usual and customary rates for the geographic area for the services. In consideration of services rendered, I hereby irrevocably assign and transfer to Infinity Family Clinic for myself and my ''dependent,'' if applicable, all rights, title and interest to the benefits payable for services rendered which are provided in any insurance policy (ies) or group health plans under which we insured or provided coverage for health benefits. This irrevocable assignment and transfer shall be for the purpose of my rights granting Infinity Family Clinic an independent right of recovery based upon their pursuit of my rights under such policies or group health plans. I hereby appoint Infinity Family Clinic as my dully authorized representative (s) and attorney-in-fact to act on our behalf, to seek payment of my benefit claims an pursue my rights to medical coverage and the benefits that flow from such coverage, to file appeals related to such claims and to request documents relevant to such claims as permitted under the claim procedure regulations under section 503 of ERISA and in accordance with 29 CFR 2560.503-1 (b)(4) and direct authorize any payor to communicate with such authorized representative (s) with a copy to me regarding all of our benefit claims with respect to Infinity Family Clinic. I specifically direct payment by any such entity or under any such plans, policies, and programs to be made directly to Infinity Family Clinic for services and items provided to me and my dependents. In the event of payment is made to me contrary to this assignment, I will promptly turn over payment in full to Infinity Family Clinic. This assignment and power of attorney includes, but are not limited, claims, or causes of action of action that I ma have relating to any insurance policy or health benefits plan or any other party under ERISA, under state insurance law and under state common law. I further assign to Infinity Family Clinic and it's agents all rights, claims or causes of action I may have to request and obtain documents from my health plan and its affiliated insurers, employees and third party administrators that relate to coverage or non-coverage of benefits or payment of charges for medical rendered, including, without limitation, my certificate of coverage, policy and/or summary plan description; any master policy governing plan document that differs from the certificate of coverage, policy and/or summary plan description; copies of any policies or procedures used to decide my claim; and a complete copy of any other claims adjudication information so that Infinity Family Clinic can determine if a full and fair review of my claim took place. I assign to Infinity Family Clinic and its agents my rights and any claims or causes of action I may have to collect any penalties for my health plan's failure to timely produce this required information.

If my account becomes delinquent and it is referred to an attorney or collection agency, I agree that I will pay all charges, interest from the due date (i.e., thirty (30) days after receipt of the clean claim) at eighteen percent (18%) or the maximum rate allowable by law, reasonable attorney fees, costs, and collection expenses.

Patient Print:_____ Signature:_____

Staff Witness Print:_____ Signature:_____