Foot and Ankle Health Center
1100 Essington Rd. *#2*
Joliet, IL 60435
815-730-8200

Legal Assignment of Benefit and Release of Medical and Plan Documents

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly toSteven Overpeck, DPM, PC. all medical benefits And/or insurance reimbursement, if any, otherwise payable to me for services rendered from such clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the provider to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release from such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby assign to the above named provider to the full extent permissible under the law and under any applicable insurance policies and/or employee health care plan any claim,
cause of action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named provider and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such provider in any attempts by such provider to pursue such claim, chose in action or right against my insurers and/or employee health care plan in my name but at such provider's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

_____ _____

Signature of Insured/Guardian Date

For Humana: I appoint Foot Health Institute to act on my behalf in connection with any claim for coverage or benefits, including receipt of any approvals or authorizations that are required before medical services. I authorize my representative to receive any and all information that is provided to me, and to act for me or for my minor dependent, in providing any information to the group health plan that relates to any claim for coverage or benefits under this group plan.

For Blue Cross Blue Shield: I authorize Foot Health Institute to act on my behalf for the purpose of claim management and payment.