CONNECTICUT CENTER
FOR PSYCHIATRIC WELLNESS

# ASSIGNMENT OF BENEFITS AGREEMENT

I, the undersigned patient, authorize benefits to be assigned to Connecticut Center for Psychiatric Wellness, LLC, ("CCPW"), for healthcare services provided to me by CCPW. I certify that the insurance information that I have provided the CCPW is true and accurate as of the date of service and that I am responsible for keeping it updated at all times. 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 may not pay 100% of the amount of the medical claim and I am responsible for payment of any and all amounts not paid by my insurance company within 90 days, including for any services which my insurance company has determined not to be covered by my policy.

I authorize CCPW to submit claims on my behalf to the insurance company listed on the copy of the current insurance card I have provided the CCPW. I assign exclusive and irrevocable right to any cause of action that exists in my favor against any insurance company or other person or entity in an amount of recovery not to exceed the extent of my bill for services provided by CCPW, including exclusive and irrevocable right to receive payment for such services, make demands in my name for payments and prosecute and receive penalties, interest, court costs and other legally compensable amounts owed by an insurance company or other person or entity. I further authorize CCPW to request and receive, on my behalf, from any insurance company or health care plan, any and all information and documents pertaining to my policy/plan, including a copy of the same and any information or supporting documentation concerning the handling, calculation, processing or payment of claims as such documents are required by law or regulation to be presented to me. In addition, I agree to cooperate and provide information as needed and appear as needed to assist in the prosecution of such claims for benefits upon request by CCPW.

I irrevocably designate, authorize and appoint CCPW as my true and lawful attorney-in-fact. This power of attorney is 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 by CCPW. This power of attorney shall automatically terminate, without formal action being taken as soon as CCPW has received payment in full and remedies under applicable regulatory guidelines for all medical care services provided to me. I confirm and ratify all actions taken by my attorney-in-fact pursuant to the authority granted herein.

I instruct and direct my insurance company to pay CCPW directly for medical services and care provided by CCPW, and to provide to CCPW any and all relevant information and documentation in connection with such payments and claims for payment. I understand 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 CCPW of service, I instruct that the insurer make out the check to me and mail payment directly to CCPW at 197 Thomas Johnson Drive, Frederick, MD 21702, for the professional or medical expense benefits otherwise payable to me under my current insurance policy as payment towards the total charges for the professional services rendered by CCPW. Upon receipt of said check, I authorize CCPW to endorse such checks for deposit only, and to deposit and apply all the proceeds toward payment on my account.

I agree and understand that any funds I receive from my insurance company in connection with medical services and care rendered by CCPW will be immediately signed over and sent directly to CCPW. This is a direct assignment of my rights and benefits under my medical policy/plan. This payment will not exceed my indebtedness to CCPW, and I agree to pay, in a timely manner, any balance of professional service charges over and above the payments made to CCPW pursuant to this assignment of benefits.

I authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. I authorize CCPW to be my personal representative, which allows CCPW to:

1. submit any and all appeals if my insurance company denies me benefits to which I am entitled
2. submit any and all requests for benefit information from my insurance company
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 CCPW's 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, I agree to 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 CCPW for acting as my personal representative.

| Signature of Patient | Name Legibly Printed | Date Signed |
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