TOTAL HEALING EXPERIENCE GROUP, LLC

ASSIGNMENT OF BENEFITS, DIRECTION TO PAY AND RELEASE AGREEMENT

The undersigned patient _____ (print name of patient/insured or parent/guardian if patient is a minor), assigns the benefits of their insurance and any overdue interest payments to **TOTAL HEALING EXPERIENCE GROUP, LLC** for services rendered to them.

DIRECTION TO PAY: The undersigned patient directs the insurer to pay the medical provider directly (i.e. payments to be mailed to and payable to the medical provider) for the services rendered. The insurer is further directed to not issue any checks or drafts in partial settlement of a claim that contain or are accompanied by language releasing the insurer or its insured from liability unless there has been a prior written settlement agreed to by the medical provider and the insurer as to the amount payable under the insurance policy or contract.

The undersigned patient agrees to pay any applicable deductible, co-payments, and any other amounts owed for services rendered after the insurance policy exhausts. The undersigned patient acknowledges that they are ultimately responsible for the payment of all medical services provided, including any attorney's fees and interest relating to the collection of such payments. In the event the subject medical benefits are disputed for any reason, including but not limited to, medical reasonableness and/or necessity, the undersigned patient hereby instructs the insurer to set aside any amount disputed and not to pay the disputed amount to anyone, including myself, or any entity until the dispute is resolved. Further, I hereby instruct the insurer to notify the provider immediately of any dispute as to payments so the medical provider can exercise its legal rights.

I understand this assignment will remain in full force and effect and will **NOT** be revoked unless the revocation is agreed to by both the medical provider **AND** the undersigned patient or the patient's attorney. This assignment applies to both past and future medical expenses. A photocopy of this assignment is to be considered as valid as an original.

Release of Information: I hereby authorize this medical provider to furnish my insurance company or companies or their representative and/or my attorney with any and all information that may be contained in my medical records, and to request a copy of my payout sheet from the insurer.

Provider Lien: In the event that the undersigned is party to any personal injury claim for which treatment has been rendered authorization is hereby given to the involved attorney to pay directly to TOTAL HEALING EXPERIENCE GROUP, LLC such sums as may be due and owing to them for medical service rendered to the undersigned both by reason of this injury and by reason of any other bills that are due to their office, and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said provider. The undersigned hereby further gives a lien on the case to said company against any and all proceeds of any settlement, judgment or verdict which may be paid as a result of the injuries for which treatment has been rendered.

Dated: _____ Patient's Name: _____ Patient's Signature: _____

(If patient is minor, signature of parent/guardian)

Dated:_____ Guardian's Name:_____ Guardian's Signature: _____

TOTAL HEALING EXPERIENCE GROUP, LLC

CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION

OUR PRIVACY PLEDGE

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

1. We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for diagnosis, assessment, or treatment of your health condition.

2. We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.

3. We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form (164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any given time for a copy.

YOUR RIGHT TO LIMIT USES OR DISCLOSURES

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

YOUR RIGHT TO REVOKE YOUR AUTHORIZATION

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this notice.

_____ _____

Printed Name Authorized Provider Signature

_____ _____

Signature Date

_____

Date