Assignment of Benefits, Designation of Authorized Representative & Appeal Rights

I, the undersigned, consent to the use of my Protected Health Information for treatment and payment for treatment. I authorize **William Penn University** to bill my insurance and assign directly to **William Penn University Sports Medicine** all medical benefit or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies and supplies rendered or provided **William Penn University Sports Medicine**, regardless of its managed care network participation status. I understand that **William Penn University Sports Medicine** share patient protected health information according to the federal and state law for treatment and payment. I hereby authorize **William Penn University Sports Medicine** to release all information necessary to secure payment of benefits to my insurance company. I authorize the use of this signature on all insurance submissions.

I authorize and name **William Penn University Sports Medicine** (or their designated representative) to act as my authorized representative to appeal claim denials on my behalf, and request that any insurer, plan or payer of health benefits accept appeals filed by my named, authorized representative on my behalf and to share all necessary information, including PHI, with my named, authorized representative for claims filed **William Penn University Sports Medicine** I am aware that I may submit additional information to be included with the appeal.

William Penn University Sports Medicine is given the right by me to

1. Make any request including providing or receiving notice of appeal proceedings and ability to appeal on my behalf.
2. Participate in any administrative actions and pursue claims regardless of network participation status.
3. Obtain information regarding the claim to the same extent as me.
4. Receive all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, rendered or provided by **William Penn University Sports Medicine**.

Unless revoked, this assignment is valid for all administrative and judicial reviews under ACA, ERISA, FERPA, Public Health Services Act, and any related or applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

Patient Signature

Printed name

Date

Relationship to Patient

If and to the degree consent is required to release personally identifiable information in these records under the Family Education Rights and Privacy Act, 20 USC 1232(g), (collectively referred to as FERPA), this signed document signifies such consent.