

Guarantor: _____ ID# _____

Patient: _____ Group# _____

Employer: _____

I hereby instruct and direct _____ Insurance Company to pay, by check, made out and mailed to:

Associates in Plastic and Reconstructive Surgery, Ltd.
7236 Jordan Drive, Suite 100A
Rapid City, SD 57702

If my current policy prohibits direct payment to the physician, I hereby also instruct and direct you to make out the check to me and mail it as follows:

Associates in Plastic and Reconstructive Surgery, Ltd.
7236 Jordan Drive, Suite 100A
Rapid City, SD 57702

For the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.** This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. "If my insurance has not paid within 90 days of my surgery, I understand I am responsible for payment in full."

A photocopy of this agreement shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjustor, or attorney involved in this case. I authorize Associates in Plastic and Reconstructive Surgery, Ltd. of Rapid City to initiate a complaint to the insurance Commissioner for any reason on my behalf.

"I have read and understand the above information, which is correct to the best of my knowledge."

Dated at Associates in Plastic and Reconstructive Surgery, Ltd. This _____ day of _____, 20_____.

Signature of Policyholder/Claimant

Witness