ANMED HEALTH

LIABILITY ASSIGNMENT

LABEL

I hereby authorize and direct any and all insurance carriers, attorneys, agencies, governmental departments, companies, individuals, and/or legal entities, which may elect or may be obligated to pay, provide, or distribute benefits to me for any medical conditions, accidents, injuries, or illnesses, past, present or future ("condition") to pay directly and exclusively in the name of AnMed Health such sums as may be owing to AnMed Health for charges incurred by me which relate directly or indirectly, to my condition, ("charges") with such payments to be made exclusively in the name of AnMed Health. I further grant a lien and assignment to AnMed Health with respect to my charges. This lien shall apply to all payers and to the full extent permitted by law. For the purpose of this agreement and lien (herein Agreement) "benefits" include personal injury protection, no fault coverage, uninsured and underinsured motorist coverage, third party liability proceeds, disability benefits, workers' compensation benefits, and other benefits or litigation proceeds payable to me for the purposes stated herein.

In the event that I retain one or more attorneys to represent me in this matter, I will direct each attorney to issue a letter of protection to AnMed Health regarding my charges. Upon issuance, I hereby agree that such letter cannot be revoked or modified without the express written consent of AnMed Health.

I authorize AnMed Health to release any information regarding my treatment pertinent to my case(s) to all payers as defined above to facilitate collection under this agreement. I further authorize and direct all payers to release to AnMed Health any information regarding any coverage or benefits which I may have including, but not limited to, the amount of the coverage, the amount(s) paid thus far, and the amount of any outstanding claims. I hereby authorize AnMed Health to file a copy of this Agreement, together with any applicable charges, with any and all payers regardless of whether a claim has been established with said payers.

This Agreement shall not be modified or revoked without mutual consent of AnMed Health and myself.

I agree that every provision of this Agreement is reasonably necessary for the protection of the right and interest of AnMed Health and me. However, should any provision of this Agreement be found invalid, illegal, or unenforceable, or for any reason cease to be binding on any party hereto, all other portions, and provisions of this Agreement shall, nevertheless, remain in full force and effect.

Patient Name (Print): _____

Patient Signature;: _____ Date: _____

Name of Custodial Parent or guardian: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Witness: _____ Date: _____