PARADIGM HEALTH SYSTEM
A NEW DIRECTION IN HEALTHCARE

Patient Name: ____ **Date:** ___________

ASSIGNMENT OF BENEFITS AUTHORIZATION FOR TREATMENT:

I authorize the providers of Paradigm Health System, L.L.C. to administer or perform medical treatment and/or services as they may deem necessary or reasonable. I further authorize Paradigm Health System, L.L.C. to release all information necessary to secure the payment of benefits and that benefits be made payable to the provider on my behalf or to myself.

I certify that I (or my dependent) have the insurance coverage that I presented and assign all benefits directly to Paradigm Health System, L.L.C. It is my responsibility to notify Paradigm Health System, L.L.C. of any changes in my health care coverage. I understand that I am financially responsible for all charges not covered by my insurance carrier, including any applicable deductibles, coinsurance and/or co-pay.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

By signing this document, I also acknowledge that I have received a copy of the organization's Notice of Privacy Practices. This acknowledgement is required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my privacy rights.

Please list below the names and phone numbers of those individuals who are permitted to discuss your care:

Name	Phone
Name	Phone
Name	Phone

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ, UNDERSTAND, AND AGREE TO ABIDE BY THE ABOVE AND THAT ALL INFORMATION GIVEN IS TRUE AND CORRECT.

Name of person signing below (print): ______________________________

Signature: ______________________________

Relationship to Patient: ______________________________

Date: ______________________________