The C.S.I.
The Center For Surgical Intervention

Patient Name: _____ Date of Birth: _____

I, the undersigned, have been informed that in the event the insurance company sends the reimbursement check to me, the insured, I am responsible for signing said check over to Brian A. Lemper, DO, Ltd or The Center for Surgical Intervention. I am aware that checks sent to me are the intended property of Brian A. Lemper, DO, Ltd. or The Center for Surgical Intervention. I am also fully responsible for the delivery of said check and correspondence EOB to Brian A. Lemper, DO, Ltd. or The Center for Surgical Intervention to 9811 W Charleston Blvd Ste 2-389, Las Vegas, NV 89117 by mail, or 5950 S Durango Dr Ste 101, Las Vegas, NV 89113 in person.

If I should fail to deliver said check in full within 10 days of receipt, I understand that I will be responsible for all billed charges. Also any agreement: verbal or otherwise, is null and void and any cash discounts I may have received as a courtesy, will be reversed and applied to my account. I also understand failure to deliver these checks and corresponding EOB's will result in my account being sent to collections with a 35% collection fee added. I also have been advised that the collections process will begin with litigation and all other courtesies will be bypassed.

Initial_____Assignment of Benefits I authorize Brian A. Lemper DO, Ltd, or The Center for Surgical Intervention to endorse and deposit checks received for payment of my health care benefits in the event they are made out to me. I hereby instruct and direct my Insurance Company to pay by check made out to **and** mailed to the following address; or if my current policy prohibits direct payment to the doctor or facility; I hereby also instruct and direct you to make out the check to me and mail it as follows:

Brian A. Lemper, DO, Ltd. Or The Center for Surgical Intervention
9811 W. Charleston Blvd Ste. 2-389, Las Vegas, NV 89117

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 balances of said professional service charges over and above the insurance payment. A photocopy of this Assignment shall be considered as effective and valid as the original. This assignment will remain effective until written notice of cancellation. I also authorize the released of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. I authorize Dr. Brian A. Lemper's office and/or The Center for Surgical Intervention.

Patient Signature	**Date**	**Witness Signature**	**Date**
Print Name	**Date**	**Print Name**	**Date**