FX RX INC.

DR. SUMIT DEWANJEE

Authorization for Release of Information: I authorize FX RX Inc. to disclose all or any part(s) of the patient's medical record to listed insurance companies and any agency conducting reviews concerning Workman's compensation care.

Medicare/AHCCCS Patient's Certification: I certify that the information given by me in applying for payment under Title XVIII and XIX of the Social Security Act is correct. I request payment be made directly to the provider of services on my behalf and I authorize said provider to release any and all information necessary regarding treatment and services provide as stated below.

Assignment of Benefits: I hereby authorize payment directly to FX RX Inc. by my insurance company(s). In the event an overpayment is made from more than one insurance company, I understand the overpayment will be sent to the appropriate payer.

Insurance: FX RX Inc. will file your insurance as a service to you. If our billing office does not hear from your insurance within 60 days, we request your help in contacting your insurance company to resolve the payment delay. The insurance plan is a contract between you and your insurance company. We must hold you responsible for any balances due.

Payment of Services: I understand I am financially responsible for all charges and fees related to the services rendered to me by FX RX Inc., I further understand that payment is full is expected upon receipt of the first statement which may include co-payments, deductibles and any services not covered by my insurance. I also understand that I am financially responsible for any charges not covered by my insurance. I hereby assign to FX RX Inc. all benefits I am entitled to receive from any person, insurance company or entity to the extent of medical charges incurred by the patient or me and authorize payment of such benefits directly to FX RX Inc. In the event my account is referred to a collection agency, I will be responsible for collection costs, including interest and reasonable attorney fees.

Health Insurance Portability and Accountability Act (HIPAA): I acknowledge that a copy of the HIPAA Notice of Privacy Practices was made available to me. I was given the opportunity to view a copy of the Notice, which describes how health information about me may be used, disclosed, and how I can get access to this information.

Valuables: I (we) understand that FX RX Inc. is not responsible for valuables and personal property brought to the facility.

I further acknowledge and grant to FX RX Inc. a lien pursuant to A.R.S. Section 33-932, et seq. against any recovery by me or any person on my behalf made against any liability, uninsured/underinsured motorists or other form of coverage or indemnity, or against a person or entity legally responsible for the medical charges incurred to the extent such charges are not paid in full by other available insurance or by me. R+FX RX Inc. and I also waive any attorney's fees or collection costs associated with the collection of medical charges pursuant to the lien hereby granted.

I CERTIFY I HAVE READ AND FULLY UNDERSTAND ALL OF THE ABOVE INFORMATION TO INCLUDE THE CONSENT FOR TREATMENT, RELEASE OF INFORMATION, INSURANCE AUTHORIZATION, AND ASSIGNMENT AND PAYMENT OF SERVICES.

PATIENT OR RESPONSIBLE PARTY SIGNATURE **DATE**