ASCEND

RELEASE OF MEDICAL INFORMATION
&
ASSIGNMENT OF INSURANCE BENEFITS

I _____("Patient") have been referred to Ascend Clinical, LLC ("Ascend") by my physician. As a laboratory, Ascend is one of my healthcare providers that will perform tests on samples during the time I receive treatment ("Medical Services") at _____ . I have already allowed my referring physician to disclose my protected health care information to other health care providers and health plans in order to provide my medical treatment, and for obtaining payment for that treatment. I now authorize Ascend to use and rely upon the medical authorization and release form provided to my referring physician for purposes of providing me Medical Services, obtaining payment for that Medical Services or in carrying out its other health care operations.

Assignment of Insurance Benefits

In consideration of the Medical Services provided to me by Ascend during the time I receive treatment from _____ , I now assign, transfer and give to Ascend all rights and interest in all benefits payable for the Medical Services provided from any Health Plan or insurance policy under which I am entitled to receive payment for the Medical Services ("Benefits"). I also assign, transfer and give to Ascend all rights and interest in any and all causes of action related to payment of Benefits against my Health Plan or any other health plan, insurance company, claim administrator or other person or organization responsible for the determination or payment of Benefits ("Responsible Parties").

Authorized Insurance Representative

In consideration of the Medical Services provided to me by Ascend during my time with_____ , I now designate Ascend as my authorized representative with respect to payment of Benefits for the Medical Services. I also grant permission to Health Plan and any Responsible Parties to discuss or disclose protected health information related to me, as applicable, to Ascend as my Authorized Representative for all purposes related to the payment of, or the failure to pay, Benefits for the Medical Services.

Financial Responsibility

I understand that I am financially responsible for payment of the Medical Services, and I may have to pay some amount, or the full amount, for these services if my Health Plan or Responsible Parties does not cover the full amount, does not pay at all, or does not pay properly.

Patient's signature:_____ Date: _____

If patient is not the person signing, please complete the below:

Name of Person signing below (please print):

_____

Relationship to Insured: _____

Signature of Parent/Guardian: _____ Date: _____

Labcheck/Spin MRN #: _____

Dialysis Facility/Physician: Please email completed form to AscendClinicalAOB@aclab.com or fax to 844.623.5093.