BRONSON

Affix Patient Label

Discharge Assignment Consent

I agree to allow Bronson Healthcare Group ("Hospital") to pursue payment of my medical bills with any payer responsible for the charges. I agree to assign to Hospital:

- All benefits payable to me by any payer for my Hospital bills.
- The right to claim benefits with any payer for payment of my Hospital bills.
- The right to bring a lawsuit against a payer for payment of my Hospital bills.
- The right to be part of any lawsuit or legal action that involves the payment of my Hospital bills.
- The right to recover interest or attorney's fees or other penalties to which I am entitled in connection with seeking payment of my Hospital bills.
- The right to appeal the denial of payment of my Hospital bills.
- The right to receive payment of my Hospital bills directly from any payer.
- The right to receive all documents to which I am entitled from any payer.

A payer is any entity providing insurance coverage or benefits for my medical care. This includes but is not limited to:

- an employer-sponsored benefit plan
- liability or health insurance carrier
- worker's disability compensation insurance carrier
- no-fault automobile insurance carrier
- the Michigan Automobile Insurance Placement Facility (MAIPF)
- Michigan Assigned Claims Plan (MACP).

I name the Hospital as my representative under the Employee Retirement Income Security Act (ERISA) for the purpose of pursuing payment of my Hospital bills.

- I agree to cooperate with Hospital in pursuing payment of my Hospital bills.
- I give up all rights to settle, release or keep payment of my Hospital bills.
- This Assignment cannot be cancelled without Hospital's written consent.

I understand that the Hospital will only try to recover my Hospital bills and not any other benefits to which I may be entitled.

If any of the conditions of this Assignment of Rights, Benefits and Causes of Action is unenforceable under any applicable law, the enforceability of the remaining conditions will not be affected in any way.

Patient Signature:_____ Date:_____ Time:_____

Parent or Guardian Signature:_____ Date:_____ Time:_____

Relationship to Patient: _____

Witness Signature:_____ Date:_____ Time:_____