IRREVOCABLE ASSIGNMENT OF HEALTH-CARE INSURANCE RECEIVABLES UNDER ARTICLE 9-SECURED TRANSACTIONS-UNIFORM COMMERCIAL CODE (SDCL CHAPTER 57A-9) and AUTHORIZATION TO RELEASE HEALTH-CARE INFORMATION

TO: _____
(Name of insurance company/attorney)

I, the undersigned, do hereby irrevocably assign, set over and grant a perfected security interest pursuant to the provisions of SDCL 57A-9 to _____ and to any and all health care insurance receivables due the undersigned as a result of health care services provided me by the above named Doctor or Clinic by reason of accident, illness or any other health related condition. This is an irrevocable assignment of my rights and benefits to any monies owed or received for my benefit in the amount equal to any outstanding balance owed by me to the above named Doctor or Clinic.

In the event my insurance company or any other party obligated to make payments to me refuses to make payment upon demand by me or the above named Doctor or Clinic, I hereby assign and transfer to said Doctor or Clinic any and all causes of action I may have now or in the future against said party and do hereby authorize said Doctor or Clinic to prosecute said cause of action in my name or the name of said Doctor or Clinic and to compromise, settle or otherwise resolve such claim or cause of action.

I understand that I remain personally liable for all amounts due to said Doctor or Clinic and that this Assignment and Authorization does not constitute consideration for said Doctor or Clinic to await payment and that the same may demand payment immediately upon rendering service and may charge interest at 15% per annum (compounded daily) on all balances after 30 days. If said Doctor or Clinic must take any collection action, I will be liable for all cost of collections actions, including court cost and reasonable attorney fees.

I authorize the above named Doctor or Clinic to release any records or information regarding my treatment to any insurance company, third party payer or attorney to facilitate collection of all benefits due me under this Assignment and Authorization and further authorize them to endorse on my behalf all checks and drafts issued to me, in my name or for my benefit.

This assignment and Authorization shall be binding upon my legal heirs, personal representative(s), successors and assigns and any other person legally acting on my behalf.

Patient's signature_____ SSN_____
Date_____

Signature of Parent, spouse or guardian authorizing care_____
Date:_____