ASSIGNMENT OF MEDICAL BENEFITS, ERISA CLAIMS AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

The undersigned assigns and conveys directly to Houston Dermatology Specialists ("HDS") all medical benefits and/or insurance reimbursements to me for services, treatments, therapies and/or medications rendered to or provided by HDS and further authorize and designate HDS as my authorized representative for purposes of all medical benefits and insurance reimbursements thereunder.

In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to HDS any legal or administrative claim or chose an action arising under any group health plan, employee benefits plan, health insurance or tort fees, or insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from HDS (including any right to pursue those legal or administrative claims or chose an action). I acknowledge and agree that this is an assignment of Employee Retirement Income Security Act, as amended (ERISA") breach of fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to HDS all my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or mediations provided by HDS including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). HDS is hereby given the right by me to (1) obtain information regarding the claim to the extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. HDS, as my assignee and my designated authorized representative, may also bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

I agree and acknowledge that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize HDS to release all medical information necessary to the applicable third parties to process my claims. Additionally, I hereby authorize my plan administrator fiduciary, agent, insurer, and/or attorney or attorney-in-fact to release to HDS all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named health care provider or its attorneys in order to claim such medical benefits.

This Assignment is valid until further revoked in writing by the undersigned.

I HAVE READ AND FULLY ACKNOWLEDGE AND UNDERSTAND THE FOREGOING.

_______________________________________ _______________________________________

Patient Signature Date