NAME_____

ASSIGNMENT OF BENEFITS & FINANCIAL RESPONSIBILTY FORM

Assignment of Benefits and Claims

I hereby assign and transfer to Advanced Orthopedic Associates of North Jersey LLC, all of my rights, titles and benefits payable by my insurance carrier for services performed by Advanced Orthopedic Associates of North Jersey LLC.

I hereby authorize Advanced Orthopedic Associates of North Jersey LLC to submit a claim to my insurance carrier or intermediary for all services rendered by Advanced Orthopedic Associates of North Jersey LLC, and to exercise any appeals and other rights under my policy on my behalf.

I authorize and assign to Advanced Orthopedic Associates of North Jersey LLC, the right to file suit and to obtain counsel and enter into legal or other actions on my behalf and/or in my name, including the arbitration/dispute resolution process, for any claims against my insurance carrier, PIP carrier, Workers' Compensation carrier, plan administrator, payor, or third party. This authorization includes the right to assignment to pursue declaratory relief or other legal remedies.

I authorize Advanced Orthopedic Associates of North Jersey LLC, to appoint an attorney to represent me directly for the collection of PIP benefits, Workers' Compensation benefits, and all other insurance benefits through the carriers themselves, plan administrator, payor or third party, I authorize Advanced Orthopedic Associates of North Jersey LLC, to obtain an attorney to represent me directly in appealing a claim to the State Health Benefits Commission for all state plans. I authorize Advanced Orthopedic Associates of North Jersey LLC, to represent me directly in appealing a claim to the appropriate Federal Agency for all federal plans.

I authorize Advanced Orthopedic Associates of North Jersey LLC, to act on my behalf and report any suspected violation of proper claims practices to the proper regulatory authorities.

I direct my insurance carrier, or intermediaries, to issue a payment check directly to Advanced Orthopedic Associates of North Jersey LLC,. If my insurance company will not directly Advanced Orthopedic Associates of North Jersey LLC, I authorize and direct that the insurance company sends all checks and copies of Explanation of Benefit forms in connection with services of Advanced Orthopedic Associates of North Jersey LLC, to 1777 Hamburg Turnpike Suite 301 as my agent for delivery of said items and use.

Financial Responsibility

I understand and agree that I am responsible for all charges incurred in connection with the receipt of services and care from Advanced Orthopedic Associates of North Jersey LLC and promise to pay promptly to Advanced Orthopedic Associates of North Jersey LLC, the amount of charges for services rendered.

I hereby authorize Advanced Orthopedic Associates of North Jersey LLC to release all information necessary regarding services rendered to my insurance company and referring physician.

ASSIGNMENT OF BENEFITS & FINANCIAL RESPONSIBILITY FORM – Page 2

I understand that regardless of my assigned insurance benefits, I am responsible for the total charges of services rendered not covered by the insurance company. I understand that co-payments or deductibles are due in full at the time of service.

I agree to cooperate, aid and assist Advanced Orthopedic Associates of North Jersey LLC, in procuring all possible insurance benefits.

Patient Receipt of Checks

In the event that I receive direct payment of any amount due for services rendered, I agree that I will hold such payment in trust for Advanced Orthopedic Associates of North Jersey LLC, and I also agree to send such payment to Advanced Orthopedic Associates of North Jersey LLC one week after receipt of same. I also agree to pay attorney's fees equal to 33 1/3% of the outstanding balance, plus court costs, in the event the account is turned over to an attorney for collection.

Consent to Disclose

I authorize Advanced Orthopedic Associates of North Jersey LLC, and its agents and attorneys to obtain medical information regarding my physical condition from any other health care provider, including hospitals, diagnostic centers, etc., and I specifically authorize such health care provider(s) to release all such information to Advanced Orthopedic Associates of North Jersey LLC about me, including medical reports, X-Ray reports, narrative reports, and any other report or information regarding my physical condition.

Failure to Comply

I understand that failure to comply with my responsibilities under this form will result in my account remaining active. I guarantee payment of all said charges incurred. In the further event that the account must be placed with an attorney, I will also be responsible for collection agency fees and costs incurred in collection.

The undersigned has read and understands the above terms.

_____ _____

Patient Signature Date