

Associated Orthopaedics

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ASSIGNMENT OF BENEFITS

PATIENT NAME: _____

I IRREVOCABLY ASSIGN TO ASSOCIATED ORTHOPAEDICS ALL MY RIGHTS AND BENEFITS UNDER ANY INSURANCE CONTRACTS FOR PAYMENT FOR SERVICES RENDERED TO ME BY ASSOCIATED ORTHOPAEDICS. I am aware that ultimately I am responsible for payment of services rendered to me that is not covered by my insurance plan (to include denials to this Practice due to my failure to obtain a referral or if I am remiss in answering any questionnaire sent to me by my insurance carrier). This assignment of benefits has been explained to my full satisfaction, and I understand its nature and effect.

I IRREVOCABLY AUTHORIZE ALL INFORMATION REGARDING MY BENEFITS UNDER ANY INSURANCE POLICY RELATING TO ANY CLAIMS BY ASSOCIATED ORTHOPAEDICS TO BE RELEASED TO ASSOCIATED ORTHOPAEDICS.

I IRREVOCABLY AUTHORIZE ASSOCIATED ORTHOPAEDICS TO FILE INSURANCE CLAIMS ON MY BEHALF FOR SERVICES RENDERED TO ME.

I IRREVOCABLY DIRECT THAT ALL SUCH PAYMENTS GO DIRECTLY TO ASSOCIATED ORTHOPAEDICS.

I IRREVOCABLY AUTHORIZE ASSOCIATED ORTHOPAEDICS TO ACT IN MY BEHALF AND REPORT ANY SUSPECTED VIOLATIONS OF PROPER CLAIMS PRACTICES TO THE PROPER REGULATORY AUTHORITIES.

PATIENT SIGNATURE: _____ DATE: _____

DISCLOSURE OF OWNERSHIP

Public law of the State of New Jersey mandates that a physician, chiropractor or podiatrist inform their patients of any significant financial interest they may have in a health care service. Accordingly, we wish to inform you that we do have a financial interest in the following health care services to which we refer our patients:

THE CENTER FOR AMBULATORY SURGERY & ASC OF UNION COUNTY

You may, of course, seek treatment at a health care service of your own choice. A listing of alternative health care service providers can be found in the classified section of your telephone directory under the appropriate heading.

Patient Signature: _____ Date: _____

_____ Effective Date: April 14, 2003

print name _____ **date** _____

Acknowledgement of Receipt of Notice of Privacy Practices

I have been presented with a copy of Associated Orthopaedics Notice of Privacy Practices detailing how my medical information, also known as "Protected Health Information" or PHI may be used and disclosed as permitted under federal and state law. I understand that I have the right to review the Notice and ask questions about Associated Orthopaedics' privacy practices. By signing this form you acknowledge that you have received our **Notice of Privacy Practices**.

Signature of patient/representative (if patient is a minor or an adult who is unable to sign)

IF PATIENT REFUSES TO SIGN, PLEASE INDICATE YOUR ATTEMPT TO OBTAIN A SIGNATURE

() Patient refused to sign this acknowledgment _____ date _____