NEW JERSEY SPORTS MEDICINE AND PERFORMANCE CENTER LLC

689 Valley Road, Suite 104, Gillette, New Jersey, 07933

CONSENT FOR ROUTINE EXAMINATION AND TREATMENT. I consent to examination, routine testing and medical care. If special procedures are needed, I will be asked to give separate informed consent.

NOTICE OF PRIVACY PRACTICES. I have read and understand my doctor's Notice of Privacy Practices.

CONSENT TO USE OR DISCLOSE MY PERSONAL HEALTH INFORMATION

I consent to my doctor's use and disclosure of my personal health information to any health care provider involved in my care, to whom I may be transferred or referred for care, and to family or others involved in my care. I consent to my doctor's use and disclosure of my health information for educational, administrative purposes, or for research when federal law allows such use without my specific consent.

I understand that when my doctor uses and discloses my health information, my doctor may also disclose HIV, substance abuse or mental health treatment information as part of my record. I consent to any such disclosure.

I consent to my doctor's use and disclosure of my health information by my doctor's staff for the purposes described above. I have the right to take back this consent, in writing, except when the Doctor's office has already made disclosures based on this consent.

ASSIGNMENT OF BENEFITS AND AGREEMENT FOR FINANCIAL RESPONSIBILITY

I assign, transfer and authorize payment to New Jersey Sports Medicine and Performance Center LLC (NJSportsmed) any health insurance benefits payable to me for my care, including Medicare, payments under any Employer Self-Funded Medical Expense Reimbursement Plan, and payments from private insurance companies.

This allows NJSportsmed to act in my place to bill and collect payments and to sue any insurer or other responsible party to obtain these payments, just as I could do. I certify that the information I gave to my doctors to bill for payment is correct. If incorrect, I may be billed directly by NJSportsmed.

Co-payments and all non-covered services and products are due at the time service is rendered unless other arrangements have been made. I am responsible for any balance, other than contractual obligations, not covered by my insurance carrier. I understand that I am ultimately responsible for payment of services and coverage determination. Should enforcement be necessary for the collection of the bill, a $50 fee will be assessed, in addition to any legal fees. I have read and understand the office and financial policies.

This payment authorization, assignment of benefits and agreement for financial responsibility is also binding on my administrators, executors, heirs, and successors.

I have read, understand, and agree to all of the above and my questions have been answered.

Patient Name or Authorized Party: _____

Signature: _____ Date: _____

Witness Name: _____ Witness Initials: _____