ASSIGNMENT OF BENEFITS, NETWORK PARTICIPATION STATUS AND FINANCIAL RESPONSIBILITY FORM

I hereby assign and transfer to Manalapan Medical Center, PA, all of my rights, title and benefits payable by my insurance carrier or other payor for services performed by Manalapan Medical Center, PA.

I hereby authorize Manalapan Medical Center, PA to submit a claim to my insurance carrier, intermediary or other payor for all services rendered by Manalapan Medical Center, PA and to exercise any appeals and other rights under my policy on my behalf.

I authorize and assign to Manalapan Medical Center, PA 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 Manalapan Medical Center, PA 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 Manalapan Medical Center, PA to obtain an attorney to represent me directly in appealing a claim to the State Health Benefits Commission for all state plans. I authorize Manalapan Medical Center, PA to obtain an attorney to represent me directly in appealing a claim to the appropriate Federal Agency for all federal plans.

I authorize Manalapan Medical Center, PA to act on my behalf and report any suspected violations of proper claims practices to the proper regulatory authorities.

I direct my insurance carrier, payor, or its intermediaries, to issue a payment check directly to Manalapan Medical Center, PA.

If the insurance company or payor will not directly pay Manalapan Medical Center, PA, I authorize and direct that the company send all checks and copies of Explanation of Benefit forms in connection with the services of Manalapan Medical Center, PA to Manalapan Medical Center, PA, at 345 Route 9 South, Manalapan, New Jersey 07726, as my agent for delivery of said items and use.

I hereby authorize Manalapan Medical Center, PA to release all information necessary regarding services rendered to my insurance company or other payor and my referring physician.

I acknowledge that I have read and understood the following. Manalapan Medical Center, PA and its health care professionals are out of network with your health insurance plan, and the estimated amount the health care professional will bill for the services is available upon request. If the network status of the health care professionals changes as it relates to your health benefits plan, Manalapan Medical Center, PA will notify you promptly. You will have a financial responsibility applicable to health care services provided and be responsible for costs allowed by your health benefits plan. Manalapan Medical Center, PA advises you to contact your carrier for further consultation on those costs. I understand that certain patient responsibility payments

such as co-payments/co-insurance are due in full at the time of service. I acknowledge that I was informed prior to my appointment about the network non-participation status of the provider.

I agree to cooperate, aid and assist Manalapan Medical Center, PA in procuring all possible insurance benefits.

Patient Receipt of Checks

In the event that I receive direct payment of any amounts due for services rendered by Manalapan Medical Center, PA, I agree to forward promptly to Manalapan Medical Center, PA any checks made payable to me for services rendered by Manalapan Medical Center, PA, endorsed to the order of Manalapan Medical Center, PA and any Explanations of Benefits (EOB) to the extent not sent directly to Manalapan Medical Center, PA. I agree to notify Manalapan Medical Center, PA upon receipt of such check and to endorse the check "Pay to the Order of Manalapan Medical Center, PA", and immediately mail the check and EOB form to Manalapan Medical Center, PA, keeping copies of the check and EOB for my records. I acknowledge that in the event I fail to forward the check to Manalapan Medical Center, PA within thirty (30) days of receipt, I may be held responsible for the total out-of-network charges for the services of Manalapan Medical Center, PA.

Consent to Disclosure

I authorize Manalapan Medical Center, PA 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 Manalapan Medical Center, PA 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 or collection agency to obtain payment, I shall be responsible for all reasonable attorney, collection agency fees and costs incurred in collection.

I understand that the information in this form supersedes the relevant information in the previously signed forms.

The undersigned has read and understands the above terms, applicable to the relationships with Manalapan Medical Center, PA and its providers (Igor Priven, MD, Inessa Grinblat, MD, Albert Sun, MD, Matthew Surgan, MD, Ira Spiler, MD, Joseph Schafer DC, Aleksandra Novik, DNP, Marina Sherman, APN, Tamkeen Shaikh, PA-C, Marina Rabkin, RD, Kanan Thakore, RD).

Full Name: _____Signature: _____ Dated:_____
(Patient)