NORTH JERSEY THORACIC SURGICAL ASSOCIATES, P.C. SIGNATURE SHEET

Patient Name: ____Date of Birth_______________

CERTIFICATION AND CONSENT

I certify that the information submitted on the patient information and medical history form is true and correct to the best of my knowledge. I give permission for the doctors to administer and perform such procedures as deemed necessary in the diagnosis and treatment of my illness.

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to North Jersey Thoracic Surgical Associates, P.C. all insurance benefits, if any, otherwise payable to North Jersey Thoracic Surgical for services rendered. I understand that I am financially responsible for all charges whether paid or not by insurance. If I receive any payments from my insurance company in error, I will sign them directly over to North Jersey Thoracic Surgical Associates. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

PERMISSION TO DISCLOSE

I hereby give permission to release my records, including all medical notes, test results, or x-rays to my spouse, parent, guardian, etc. Also, I give permission to be reminded of appointments by telephone and to leave a message on an answering machine or with an answering person. This permission will remain in force until denied.

_______________________________ _____________________

Responsible Party Signature Date

NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have the option of having a copy of North Jersey Thoracic Surgical Associates Notice of Privacy Practices. I understand that the notice sets forth my rights relating to the use and disclosure of my personal health information and explains how North Jersey Thoracic Surgical Associates may use or disclose my personal health information both with and without my authorization. I further understand that I may contact Susan Mutz if I have any questions regarding the contents of this Notice of Privacy Practices or to file a complaint about the privacy practices of North Jersey Thoracic Surgical Associates.

_______________________________ _____________________

Responsible Party Signature Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made to either me or on my behalf to North Jersey Thoracic Surgical Associates for any services furnished me by those physicians. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed for payment to be made and authorize release of medical information necessary to pay claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

______________________________ _____________________

Beneficiary Signature Date