

North Jersey Rheumatology Associates P.C.

312 Belleville Turnpike, Suite 3A, North Arlington, NJ 07031

631 Broadway, Bayonne, NJ 07002

680 Kinderkamack Road, Oradell, NJ 07649

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I, _____ hereby consent to medical treatment. In addition, I give permission to have any subsequent treatment as deemed necessary as long as the risks and complications are discussed with me prior to the procedure. I authorize the release of medical information to my primary care or referring physician, consultants if needed and as necessary to process insurance claims, applications, and prescriptions. I also authorize the payment of medical benefits to the physician.

As a participating provider we will bill your insurance company for any eligible charges that you may incur regarding office visits or any other procedures. You will be responsible for payment of any non-covered charges, co-insurance and deductible amounts according to your policy provisions. All HMO's must have the required referral from your primary physician at the time of your visit. If the referral is not presented you are required to pay for the visit at the time of your appointment. If a claim is denied because an improper referral was made, the charges then become your responsibility. Your health insurance coverage is a contract between you and your insurance company. It is your responsibility! This office cannot accept responsibility for negotiating any type of settlement on a dispute claim if your referrals or pre-authorizations are not obtained. In addition, if your insurance company has not paid the claim we submitted on your behalf, within 90 days, payment of charges will then become your responsibility. We accept payment in the form of cash, credit card and check. There will be a \$20 fee for all returned checks.

I understand the billing policy of this office as described above and agree to be financially responsible for my treatment.

Signed

Date