ENGLEWOOD SPORTS MEDICINE ORTHOPAEDIC SURGERY, P.C.

DISCLOSURE OF INSURANCE PARTICIPATION
STATUS AND FEES

The laws of the State of New Jersey and New Jersey Department of Health require that a health care professional inform patients of the health care plans in which the professional participates in and the facilities with which the professional is affiliated. In compliance with these laws, the undersigned patient is hereby notified, in writing, that:

SECTION ONE: HEALTH PLANS SURGEON PARTICIPATES WITH:

Our surgeons presently participate with the following health insurance plans:

1. Medicare
2. Oscar Insurance

If your health plan is not listed above in this Section One, your doctor does not participate with your health plan. In order to proceed with any health care services, you, the patient, must complete, sign and date this form.

SECTION TWO: HOSPITALS SURGEON IS ASSOCIATED WITH:

Our doctors presently have privileges at the following hospital to perform surgical procedures:

1. Englewood Hospital & Medical Center
   350 Engle Street, Englewood, NJ 07631
2. Hudson Regional Medical Center
   55 Meadowlands Parkway, Secaucus, NJ 07094
3. HMH Palisades Medical Center
   7600 River Road, North Bergen, NJ 07047
4. Bayonne Medical Center
   29 East 29th St, Bayonne, NJ 07002

Please contact your health plan or the hospital at which you are to receive surgical services to determine the participation status of the hospital, other providers and services the hospital is affiliated with, and associated cost obligations for you, the patient, prior to booking your procedure.

SECTION THREE: AMBULATORY SURGICAL CENTERS SURGEON IS ASSOCIATED WITH:

Our doctors presently have privileges at the following ambulatory surgical centers to perform surgical procedures:

1. Hudson Crossing Surgery Center
   2 Executive Drive, Fort Lee, NJ 07024
2. Rockland & Bergen Surgery Center
   133 N. Kinderkamack Road, Montvale, NJ 07645
3. Advanced Spine & Outpatient Surgery Center,
   347 Mount Pleasant Ave., West Orange, NJ 07052

Please contact your health plan or the Ambulatory Surgical Center at which you are to receive surgical services to determine the participation status of the hospital and associated cost obligations for you, the patient, prior to booking your procedure.

SECTION FOUR: LICENSED HEALTHCARE STAFF:

The following licensed healthcare professionals may perform assistant services on you, the patient, based upon the treatment plan and needs of the patient:

1. Dr. Robert Doidge, D.O.
2. Dr. Wasik Ashraf, D.O.
3. Dr. David Kovacevic, M.D.

Location:

1. 370 Grand Ave, Suite 100,
   Englewood, NJ 07631

SECTION FIVE: ANESTHESIA, RADIOLOGY, LABORATORY, PATHOLOGY SERVICES:

The following outside service providers may be contracted to perform services on the patient based upon the treatment plan and needs of the patient:

1. Hudson Crossing Surgery Center*
   2 Executive Drive, Fort Lee, NJ 07024
2. Rockland & Bergen Surgery Center
   133 N. Kinderkamack Road, Montvale, NJ 07645
3. Advanced Spine & Outpatient Surgery Center, 3rd Floor
   347 Mount Pleasant Ave., West Orange, NJ 07052

*Dr. Robert Doidge has financial interest here.

cont'd.

The patient is hereby notified and understands that these assistants, anesthesia, radiology, laboratory and/or pathology services may **not** participate with any health insurance plans and may be "out-of-network" providers subject to the following disclosures. Patient should inquire with each provider to determine their participation status and/or contact patient's health plan or administrator for further consultation on costs associated with these services.

SECTION SIX: MANDATORY DISCLOSURES & PATIENT ACKNOWLEDGMENT:

1. I understand that the surgeon that I am seeking healthcare services from is "out of-network" with and does not participate with my health insurance plan;

ⓧ _____
PATIENT'S INITIALS

2. I understand that the amount or estimated amount the surgeon will bill me, the covered person, or my health plan, for the services is available upon request;

ⓧ _____
PATIENT'S INITIALS

3. I may request from the surgeon an estimated charge for the services proposed and the Current Procedural Terminology (CPT) codes associated with that service, and the surgeon shall disclose to me, the patient, in writing, the amount or estimated amount that the surgeon will bill me, the covered person, or my health plan, for the service and the CPT codes associated with that service, absent unforeseen medical circumstances that may arise when the health care service is provided;

ⓧ _____
PATIENT'S INITIALS

4. I understand that I will have a financial responsibility applicable to health care services provided by an out-of-network professional, that may be in excess of my in-network copayment, deductible, or coinsurance, and that I may be responsible for any costs in excess of those allowed by my health benefits plan; and

ⓧ _____
PATIENT'S INITIALS

5. I have been advised that I should contact my health insurance plan or administrator for further consultation on those costs.

ⓧ _____
PATIENT'S INITIALS

The surgeon and patient both acknowledge and agree that receipt or acknowledgement by patient of these disclosures shall not waive or otherwise affect any protection under existing statutes or regulations regarding in-network health benefits plan coverage available to the patient, under the law.

The surgeon further acknowledges and agrees that, if, between the time these disclosures are made to the patient and the time the health care service takes place, the network status of the surgeon or any of the health care professionals listed in this disclosure change as it relates to the patient's health benefits plan, the surgeon shall notify the patient promptly.

SECTION SEVEN: ACKNOWLEDGEMENT OF RECEIPT OF DISCLOSURES

I, the undersigned patient, acknowledge receipt of this disclosure form from my surgeon, and have read it and understand the contents. I have discussed my option to obtain treatment with other surgeons, health care providers, service providers, or at alternative health care facilities that may participate with my health plan and I waive the right to do so and wish to obtain my treatment with this surgeon with full notice of these disclosures and potential cost sharing consequences. I certify that I am at least 18 years of age, competent, not under the influence of any drug, alcohol or other substance that would impair my ability to understand these disclosures, am not being coerced to sign this disclosure, and do so upon my own free will.

_____
SIGNATURE

_____
PRINT NAME

_____
DATE