Active
Orthopedics & Sports Medicine, LLC

Michael L. Gross, M.D.
Chief, Sports Medicine Service
Hackensack Univ. Medical Center
Fellowship Trained Sports Medicine
Board Certified Orthopedic Surgery
and Sports Medicine

Oscar Vazquez, M.D.
Fellowship Trained Sports Medicine
Fellowship Trained Shoulder, Elbow Reconstruction
Board Certified Orthopedic Surgery

A. Ylenia Giuffrida, M.D.
Fellowship Trained in Hand, Upper Extremity
and Microvascular Surgery
Board Certified Orthopedic Surgery

Richard D. Rhim, M.D.
Fellowship Trained, Spine Surgery
Minimally Invasive Spinal Surgery
Board Certified Orthopedic Surgery

James C. Natalicchio, M.D.
Fellowship Trained Interventional Spine Care
Board Certified Physical Medicine
and Sports Medicine

Michael T. Benke, M.D.
Fellowship Trained, Sports Medicine
Board Certified Orthopedic Surgery

Thomas K. John, M.D.
Fellowship Trained, Total Joint Reconstruction
Board Certified Orthopedic Surgery

Ira Esformes, M.D.
Chairman, Orthopedic Surgery
Hackensack UMC at Pascack Valley
Board Certified Orthopedic Surgery
and Sports Medicine

Ralph C. Napoli, D.P.M.
Chairman, Podiatric Surgery
Hackensack UMC at Pascack Valley
Board Certified Foot, Ankle Surgery

Raghu Maddela, M.D.
Fellowship Trained, Spine Medicine
Board Certified Physical Medicine
and Rehabilitation

Michelle Joseph, P.A.
Physician Assistant

Nicole Jahn, P.A.
Physician Assistant

Sabrina Shahbahrami, P.A.
Physician Assistant

ASSIGNMENT OF BENEFITS

I irrevocably assign to you, my medical provider, all of my rights and benefits under my insurance contract for payment for services rendered to me. I authorize you to file insurance claims on my behalf for services rendered to me and this specifically includes filing arbitration/litigation in your name on my behalf against the PIP carrier/health care carrier. I irrevocably authorize you to retain an attorney of your choice on my behalf for collection of your bills. I direct that all reimbursable medical payments go directly to you, my medical provider. I authorize and consent to your acting on my behalf in this regard and in regard to my general health insurance coverage pursuant to the "benefit denial appeals process" as set forth in the NJ Administrative Code.

In the event the insurance carrier responsible for making medical payments in this matter does not accept my assignment, or my assignment is challenged or deemed invalid, I execute this limited/special power of attorney and appoint and authorize your collection attorney as my agent and attorney to collect payment for your medical services directly against the carrier in this case, in my name, including filing an arbitration demand or lawsuit. I specifically authorize that attorney to file directly against that carrier in my name or in your name as a medical provider rendering services to me and designate your collection attorney as my attorney in fact. I further grant limited power of attorney to you as my medical provider to receive and collect directly from the insurance carrier money due you for services rendered to me in this matter, and hereby instruct the insurance carrier to pay you directly any monies due you for medical services you rendered to me. I authorize you and or your attorney to receive from my insurer, immediately upon verbal request, all information regarding last payment made by said insurer on my claim, including date of payment and balance of benefits remaining.

I authorize you and or your attorney 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 you about me, including medical reports, X-ray reports, narrative reports, and any other report or information regarding my physical condition.

I authorize Active Orthopedics and Sports Medicine, LLC to furnish my records of medical history for services rendered or treatment given to me for the purpose of review of filing a claim with my insurance carrier. If applicable, I also request payment of government benefits to the part who accepts assignment.

I understand that I am responsible for all deductibles, co-insurance, co-payments or any portion of the bill that my insurance company does not approve/deny. I understand that if required, a valid referral is due at the time of services; otherwise my appointment will be rescheduled.

Dated: _____ Patient's Signature _____

Patient's Signature