Out of Network Billing

By his or her signature below, the undersigned patient/beneficiary (the "Patient/Beneficiary")

is aware that he or she has paid for a health insurance plan that includes out-of-network benefits. It is the intention of the Patient/Beneficiary that this statement shall serve as official notification that Patient/Beneficiary has elected to the Patient/Beneficiary's out-of-network benefits as outlined in his or her health insurance plan and that the Patient/Beneficiary understands the implication of such election.

The Patient/Beneficiary understands that the hospital/provider he or she has selected, namely,

_____ GREATER PHOENIX ORTHOPEDICS LLC;

_____ MARTIN ORTHOPEDICS CONSULTING LLC;

_____ R&E ASSISTS LLC;

is not participating in his/her health insurance plan's network.

The Patient/Beneficiary understands that the benefits received from his or her health insurance plan for the services provided by the Provider the Patient/Beneficiary has selected will be out-of-network benefits, which are different than in-network benefits.

Should this election for out-of-network benefits (as stated above) be prohibited in part or in whole under any provision of Patient/Beneficiary's policy/plan, please advise and disclose in writing, within 30 days after your receipt of this selection by the Patient/Beneficiary, to his or her Provider and to the Patient/Beneficiary, the specific plan provision that prohibits Patient/Beneficiary from electing out-of network benefits; otherwise, this election should be reasonably expected to be effective.

If you do not wish to approve Patient/Beneficiary's claim as submitted, please promptly provide the necessary claim forms, instructions, reasonable assistance and documents including the Summary Plan Description, that were relied upon to make the decision so that the Patient/Beneficiary may comply with the policy conditions and the insurer's reasonable requirements.

Patient Signature: _____ Date: _____