AUTHORIZATION AND CONSENT FOR ASSIGNMENT OF ANESTHESIA BENEFITS AND RELEASE OF INFORMATION TO INSURANCE COMPANY OR HEALTH MAINTENANCE ORGANIZATION.

I hereby assign payment to FIFTH AVENUE ANESTHESIA ASSOCIATES, P.C. (FAAAPC) of insurance benefits otherwise payable to me, but not to exceed the balance FAAAPC regularly charges for the episode of anesthesia care. I understand that I am financially responsible to FAAAPC for charges not covered by the authorization, which may include care delivered to me by an anesthesia provider who does not participate with my insurance company or health maintenance organization. Authorization is herby granted to release to FAAAPC'S INSURANCE COMPANY(S) information as the company (s) may request to complete the insurance claim, where applicable.

CERTIFICATION FOR MEDICARE PATIENTS (ONLY)

Patient's certification. Authorization to release Information and Payment Request

I certify that the information given by me in applying for payment under title XV111 of the Social Security Act to be correct. I authorize any holder of medical and other information about me to release to the Social Security Administration or its intermediaries claim. I request payment or authorized benefits to be made in my behalf, where applicable.

POST OPERATIVE PHONE CALL

A nurse will be calling you after your surgery. If you are not available or not at home, we may leave a message on your answering machine or with the person who might answer your phone to request that you call the Center at your earliest convenience. If that is not what you wish, please inform the nurse when you are admitted.

________________________ ____

Patient's Signature **Signature of Person authorized to consent for Patient**

___________________ _______________________

Date **Relationship to Patient**

KD/dr/2008