OCEAN RENAL ASSOCIATES, P.A.

I hereby authorize my Insurance Company to pay by check made payable and mailed directly to the Physicians named below:

Ocean Renal Associates 210 Jack Martin Blvd Suite D-1 Brick, NJ 08724

For the medical and surgical benefits allowable, and otherwise payable to my current insurance policy, as payment toward the total charges for the services rendered. I understand that as a courtesy to me, the Physician and/or HPSA will file a claim with my insurance company on my behalf. However, I am financially responsible for, and hereby do agree to pay, in a current manner, any charges not covered by the insurance payment. If it necessary to file a formal collection action, I agree to pay all costs, including reasonable attorney's fee incurred by the outpatient medical center in the collection of the outstanding fees.

X_____

Patient Signature or Responsible Person Date