https://cedarknollssurgicalcenter.com/

SURGICAL CENTER
AT CEDAR KNOLLS

DISCLOSURE OF FINANCIAL INTEREST IN SURGICAL CENTER

Public law/rule of the State of New Jersey/Board of Medical Examiners mandates that a physician, podiatrist and all other licensees of the Board of Medical Examiners inform patients of any significant financial interest held in a health care service. Accordingly, please take notice that practitioners in this office do have a financial interest in the following health care service(s) to which patients are referred:

1. Surgical Center At Cedar Knolls, LLC

You may, of course, seek treatment at a health care service provider of your own choice. A listing of alternative health care service providers can be found in the classified section of your telephone directory under the appropriate heading.

Additionally, please be advised that the procedure(s) you are scheduled to undergo at Surgical Center at Cedar Knolls, LLC may be considered to be "out-of-network services, and reimbursed at an "out-of-network" level by your insurance carrier.

The Centers for Medicare & Medicaid Services Conditions of Coverage regarding ambulatory surgical centers mandate that ambulatory surgical centers disclose to patients a physician's financial interest in an ambulatory surgical center to which the physician refers his or her patients. Accordingly, please take notice of the following information:

1. The following physicians are ownership partners in Surgical Center at Cedar Knolls LLC, a surgical center to which they refer patients:

1. Physician Owners of Surgical Center At Cedar Knolls, LLC

R. Boiardo, MD
R. D'Agostini, MD
D. Epstein, MD
R. Fox, MD
R. Goldman, MD

S. Hunt, MD
A. Kirschenbaum, MD
M. McBride, MD
K. Montgomery, MD
A. Willis, MD

J. Shearin, MD
L. Shrem, MD
R. Thiele, MD

Please sign below to acknowledge that you have been informed of the ownership interest in the above entity prior to or at the time you were referred to the above entity.

______________________________ ______________________________

PATIENT'S NAME (Please Print) Date:

____

PATIENT SIGNATURE