Alden Leifer, MD & Associates **Patient Acknowledgements**

The best medical care can be provided only on the basis of mutual understanding. We encourage you to discuss any questions you may have regarding our policies with our billing staff.

Insurance Information – Co-Payments and Deductibles
We participate in a variety of insurance plans and will directly bill your insurance under these plans. Payment is required for all services at the time they are rendered. All applicable co-payments and deductibles will be collected at the time of service. An administrative billing fee of $5 will be applied if payment is not made at the time of service. Please note most insurance companies do not cover refractions or routine eye exams.
I understand services and fees not covered by my insurance are my responsibility.
Initial _____

Referral Information
Some insurance plans require you to obtain a referral for services from your primary care provider. This is required by your insurance before you visit our office, even when the visit is for an urgent problem. Contact your insurance company if you have questions, or contact the office of your primary care proider.
I understand, that if needed, it is my responsibility to obtain a referral from my primary care provider and have it present at the time of today's visit. I further understand it is my responsibility to keep track of the number of visits available as well as the expiration date and obtain a new referral as needed.
Initial _____

We Participate with Medicare
We are participating providers under Medicare. This means we accept the fees set by Medicare for medical services covered by the Medicare program, including surgery. **I understand I will be responsible only for my 20% copay, deductibles and non-covered services, such as refractions and routine eye exams.**
Initial (Medicare subscribers only) _____

HIPPA Policy
Patients are protected under the Federal Health Insurance Portability and Accountability Act. This Federal Law prohibits any staff member of Dr. Leifer's office from discussing appointments, medication, test results or treatment plans with anyone other than the patient. Often, this causes difficulty for some patients who would like family members or caretakers to obtain information for them. If you would like to permit someone to discuss your medical condition, confirm appointments or obtain results for you, please indicate their name(s) below. Only these individuals will be provided with information.

Name of Individual	Relationship to Patient

Notice of Privacy Policy Patient Acknowledgment
I understand that under the Health Insurance Portability Accountability Act of 1998. I have certain rights to privacy in regards to my protected health information. I have received, read and understood the Notice of Privacy Policy for the above named practice.

The provider reserves the right to change the terms of the Notice of Privacy Policy. I understand the Provider will supply a current Notice of Privacy Policy upon request.

I certify that the information I have provided is correct. I authorize the release of medical information if necessary to process insurance claims to insurance companies or their agencies (including Medicare), for the purpose of filing and payment of medical claims. I authorize payment of medical benefits to the provider.

Signature:

_____ _____

(Signature of patient, parent or authorized person) (Today's Date