Andrew E. Leifer, M.D., P.C.
Apex Treatment Services
1202 Bergen Parkway, Suite 211
Evergreen, Colorado 80439

General Adult Psychiatry
Addiction Medicine
Outpatient Care
Medical Consultation-Liaison Services

Telephone (303) 674-6074

ALTERNATE PAYER INFORMATION

Patient Name: _____

Alternate Payer Name: _____

Payer Physical Street Address: _____

_____
City **State** **Zip**

CREDIT CARD INFORMATION:
Name as it appears on Credit Card: _____

Credit Card Number: _____

Expiration Date: _____ **CVC (3-digit code on back of card):** _____

Credit Calling Billing Address (if different than above): _____

Home Phone # : ( ) **Cell Phone # : ( )**
Phone associated with Credit Card Statements: Home ❑, Cell ❑, or Other:_____

Social Security # :_____ **Date of Birth :**_____

Name of Employer:_____

Employer Address:_____

FINANCIAL POLICY:
FULL PAYMENT IS DUE AT THE TIME OF SERVICE. I ACCEPT CASH, CHECKS, OR CREDIT CARDS.

Thank you for choosing us as your health care provider. We are committed to the success of treatment. The following is a statement of our financial policy which we require you read and sign prior to any treatment. All patients must complete the Personal Information Form and Alternate Payers must sign this financial policy before the first appointment.

I understand and agree that I am responsible for the cost of the above patient's treatment with Dr. Leifer. Dr. Leifer's billing service can provide the patient with a completed HICFA (standard insurance company billing form) that may be submitted to their insurance company for direct reimbursement, however Dr. Leifer provides no guarantee that the insurance company will provide any reimbursement for services. I also agree that if it becomes necessary to forward this account to a collection agency that, in addition to the amount owed, I will be responsible for reasonable cost of collection, including attorney's fees. I understand that I will be charged for all appointments not cancelled 72 hours (three business days) in advance by the patient and all exceptions to this must be negotiated with our office.

This agreement remains in effect during the course of the patient's treatment with this office and may be revoked in writing. Please notify us of changes to your card information such as new expiration dates or other updates. Charges will appear on your card statement from Apex Treatment Services. Please contact us with any questions you may have regarding payment for treatment. We require that patients with an alternate payer maintain a limited release of information on file for you so that we may discuss financial matters associated with this treatment and we welcome your input.

Payer Printed Name:_____

Payer Signature:_____ **Date:**_____