Andrew E. Leifer, M.D., P.C.
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Evergreen, Colorado 80439

General Adult Psychiatry
Outpatient and Hospital Care
Medical Consultation-Liaison Service

Telephone (303) 674-6074
Fax (303) 831-9601

PERSONAL INFORMATION

Full Legal Name: _____

Address: _____
City **State** **Zip**

Residence Phone # : (____) _____ **Work Phone # :** (____) _____

Email: _____

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

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Primary Insurance : _____ **Ins. Co. Phone #:** _____

Name of Person Insured: _____

Subscriber (ID) # : _____ **Group # :** _____

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Secondary Insurance : _____ **Ins. Co. Phone #:** _____

Name of Person Insured: _____

Subscriber (ID) # : _____ **Group # :** _____

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Name of Employer: _____

Employer Address: _____

Spouse's Name: _____ **Spouse's Employer:** _____

Person Responsible for Charges: _____

FINANCIAL POLICY

Thank you for choosing me as your health care provider. I am committed to the success of your treatment. The following is a statement of my financial policy which I require you read and sign prior to any treatment. All patients must complete the Personal Information form and sign this financial policy before the first session.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE. I ACCEPT CASH OR CHECKS.

Your Responsibilities:

I understand and agree that I am responsible for the cost of my treatment with Dr. Leifer. Dr. Leifer's billing service can provide me with a completed HCFA (standard insurance company billing form) that I may submit to my insurance company for direct reimbursement, however Dr. Leifer provides no guarantee that my insurance company will provide any reimbursement for services. I also agree that if it becomes necessary to forward my account to a collection agency that, in addition to the amount owed, I will be responsible for reasonable costs of collection, including attorney's fees.

I understand that I will be charged for all appointments not cancelled 72 hours in advance and all exceptions to this must be negotiated with Dr. Leifer.

Printed Name: _____

Signature: _____ **Date:** _____