



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

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

**Telephone (303) 674-6074**

PERSONAL INFORMATION

**Full Legal Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_  
City State Zip

**Home Phone:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_

**Email:** \_\_\_\_\_

**Social Security # :** \_\_\_\_\_ **Date of Birth :** \_\_\_\_\_

**Are you a Medicaid or Medicare recipient: (circle one) NONE / MEDICAID / MEDICARE**  
 We **are not** a Medicaid providers. If you have or obtain Medicaid coverage that includes mental health services, we **are not** able to offer mental health services to you. You agree to notify us immediately should you obtain Medicaid.

**Primary Insurance :** \_\_\_\_\_ **Ins. Co. Phone #:** \_\_\_\_\_

**Name of Person Insured:** \_\_\_\_\_ **Subscriber (ID) #:** \_\_\_\_\_ **Group #:** \_\_\_\_\_

**Secondary Insurance :** \_\_\_\_\_ **Ins. Co. Phone #:** \_\_\_\_\_

**Name of Person Insured:** \_\_\_\_\_ **Subscriber (ID) #:** \_\_\_\_\_ **Group #:** \_\_\_\_\_

**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:** \_\_\_\_\_