Sanford G. Feldman MD, Inc.
3737 Moraga Ave, Suite A105
San Diego, CA 92117

Cash Pay
Payment in full is due at the time of service.

Co-payment, Deductibles and Patient Portion
In addition to your office visit co-pay (if you are subject to one), other amounts may be the patient's responsibility. These amounts will be billed to you after the contractual adjustments have been made. Included may be charges that have been applied to your annual deductible, or the amount due between the insurance carrier's allowable and the amount paid.

Appointment Cancellation Charge
We understand that emergencies do happen, but, this office requires 24 hours notice of a cancellation of an office visit. Patients who give less than 24 hours notice or do not show for their appointment may be subject to a $75 fee.

Collections
Should your account be referred to a collection agency and/or attorney, you will be responsible for all reasonable collection costs.

Disclaimer
This information does not pre-authorize payment. In order to receive benefits, all members must be covered at the time of service. The benefits information is not all-inclusive. It is limited to some coverage highlights. Other terms and limitations may apply even though such provisions are not indicated here. All claims are subject to medical review according to the information submitted and subject to benefit maximums and other terms of the member's contract. **It is the patient's responsibility to know the provisions of his/her plan**. Should you have questions regarding your policy, call the phone number on your insurance card.

Patient Signature: _____ Date: _____

Print Patient Name: _____

AUTHORIZATION TO RECEIVE/RELEASE HEALTH INFORMATION

Due to the HIPAA Compliance Privacy Laws of the Federal Government, it is mandatory that we ask you to review and answer the following questions listed below.

Name: _____

May we leave messages/detailed medical information on voicemail at either of these phone numbers?

□ Yes □ No Home Phone: _____ □ Yes □ No Cell Phone: _____

May we call you and/or leave messages at your place of employment? □ Yes □ No

If yes: Work Phone: _____ Extension: _____

May we email you messages/detailed medical information? □ Yes □ No

Email Address: _____

Do you have any particular person or family members that you authorize to receive and discuss information regarding your personal health information (general information, surgical, and billing)?

□ Yes □ No If yes, please provide:

Name: _____ Relationship: _____

Phone Number: _____ Alternate Number: _____

I hereby authorize **One to One Lasik** to obtain or release any and all pertinent information regarding my medical care, as needed, to assist in my ongoing treatment to or from other health care providers, laboratories, radiology facilities or other institutions. **This authorization remains in effect until revoked.**

I have reviewed the aforementioned information and provide my consent regarding any and all the issues as stated above.

I have reviewed Sanford G. Feldman, M.D., Inc.'s Notice of HIPAA Privacy Policy. A copy of this policy will be provided to me upon request.

Patient Signature: _____ Date: _____

Witnessed By: _____

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