

Advanced Beneficiary Notice

I have been informed that my insurance company will reimburse Dr. Louis Sobel only for services that it determines to be "reasonable and necessary" and that it may deny payment on some or all of the services. It is also possible that payment may be denied for other reasons, including failure to obtain proper referral, terminated insurance policy, and lack of coverage for certain services as outlined in policy. If the insurance company denies payment, I will personally and fully be responsible for the payment. I will also be responsible for all deductibles and unpaid "allowable amounts," co-pays and co-insurance, as specified by my insurance coverage.

Cancellation Policy

Appointments that are not cancelled with a 24 hour advanced notice may result in a charge for the office visit.

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Louis I. Sobel, MD, PC and the staff of Louis I Sobel MD, PC and Eastside Optical (heretofore referred to as Louis I. Sobel MD, PC) to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO).

I have been informed of my right to review the Notice of Privacy Practices prior to signing this consent for a more complete description of such uses and disclosures. I am aware that Louis I. Sobel, MD, PC reserves the right to revise its Notice of Privacy Practice at any time, and that in this event a revised Notice of Privacy Practices may be obtained by forwarding a written request to the office manager, the Privacy Official.

With this consent, Louis I. Sobel, MD, PC may call my home or other alternative location and leave a message on the voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any calls pertaining to my clinical care.

With this consent, Louis I. Sobel, MD, PC may e-mail or fax to my home or other alternative location any items that assist the practice in carrying out TPO, such as prescriptions.

I have the right to request that Louis I. Sobel, MD, PC restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Louis I. Sobel, MD, PC's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Louis I. Sobel, MD, PC may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Print Name of Patient

Print Name of Legal Guardian

Date