

I, the undersigned, fully consent to the consultation. I also acknowledge responsibility for the payment of all services. Unless I have arranged otherwise, I will pay for the services at my first office visit.

There will be a \$50.00 charge for missed appointments that are not cancelled at least 24 hours in advance.

Any non-covered services, co-payments, and /or deductibles not paid by the insurance plan will be my responsibility.

Signature: \_\_\_\_\_

**FOR MEDICARE PATIENTS ONLY**

I request payment of authorized Medicare and Medigap(Blue Cross, etc.) benefits be made to the office of Eric R Mandel, M.D., P.C., for any services provided me by this office. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature: \_\_\_\_\_

So that we may honor your privacy, please answer the following questions:

May we telephone or leave a message on your home answering machine?	YES	NO
May we leave a message at your place of employment?	YES	NO
May we discuss your medical condition with a family member?	YES	NO

\*If yes, name of family member: \_\_\_\_\_ Relationship: \_\_\_\_\_

Signature: \_\_\_\_\_