# LESLEY J. ANDERSON M.D.
# ROBERT J. PURCHASE M.D.

**WELCOME TO OUR OFFICE!**

**Please take a moment to review our office polices.**

Our office will bill your insurance company for services performed in our office. **You are responsible for any deductibles or co-payments.** Copays are **due at the time of your office visit.** We do our best to assist you in authorizations and benefits. But it is important to remind you that it is your responsibility to know and understand the policies and benefits for your insurance plan.
Initial: _____

Unless **cancelled** at least **24 hours in advance**, it is our **policy to charge $25** for missed appointments or "no-shows". You will be responsible for paying the missed appointment fee regardless of your insurance coverage. This includes Workers Compensation patients. Your insurance will not pay this fee.
Initial: _____

Our office provides phone follow up appointments in lieu of in-office follow ups for $50 in selected situations. If you chose this option, payment will be due at the time the phone follow up call is scheduled. We cannot bill your insurance for this as they do not reimburse phone appointments at this time.
Initial: _____

Many of you may have disability insurance forms. We **require five working days** to fill these out as the forms often take substantial amounts of time to complete. There is a **$40 charge for private disability forms** (ie: Aflac, Colonial) and a **$20 charge for State Disability (EDD) and FMLA forms**. This is to **be paid in advance** at the time the forms are dropped off. If you need the form expedited within 24 hours, there will be an additional $10 fee. If **medical records** are requested, there is a **$0.25 per page charge**. This is not billed to your insurance company.
Initial: _____

We will be able to provide a one time copy of your medical records provided that the records are fewer than 50 pages. If the **records exceed 50 pages**, there will be a charge **of $30 each time records are requested**, to cover the cost of time and materials. Five working days are needed for completion of your request. There is an additional $10 fee if the records need to be rushed or completed with 24 hours. To protect your privacy, no records will be released without your written consent.
Initial: _____

## Patient Disclosure

California Law imposes disclosure requirements for Physicians that have a financial interest in a facility to which they refer patients. In compliance with the law, please be advised that if you need surgical treatment, Dr Anderson has a financial interest in the Pacific Heights Surgery Center of San Francisco, where your surgery may be performed. If you prefer that your surgery NOT be performed at Pacific Heights Surgery Center, please let our office know so that we can make other arrangements for your surgery.

Federal Law imposes disclosure requirement of Physicians to inform patients in writing that patients may obtain MRI, CT or PET scans from a person or facility other than the locations the referring physician may suggest. Our office will provide you with a list of providers in the area where you reside if requested.

By signing below you acknowledge that you have read and understand the above.

_____
Print Name of Patient

_____ Date _____
Signature of patient or patient's representative

2100 Webster St. Suite #309 San Francisco CA 94115 (415) 923-3029 Fax (415) 345-9319