

PATIENT CONTACT INFORMATION SHEET

Patient Name: _____

Social security # _____ Date of Birth _____

Street Address: _____

City/State/Zip: _____

Home Phone: _____

Best time to use this number: _____

Work/Office Phone: _____ Location (city) _____

Email: _____

Cell Phone: _____

Best time to use this number: _____

FAX: _____ okay to Fax private information? (Yes) (No)

Emergency Contacts: _____ Blood Type _____

Personal (spouse, parent): Name: _____

Relationship: _____ Location (city) _____

Best Contact Number: Day: _____ Evening: _____

Pharmacy: (traditional and compounding)

Name: _____ Phone: _____ Fax: _____

Name: _____ Phone: _____ Fax: _____

Physician contacts, including Name/Specialty/Phone Number for each contact:

1) _____

2) _____

3) _____

PATIENT INSURANCE INFORMATION

Patient Name: _____

Date of Birth: _____ **Social Security #** _____

Primary Insurance:

Company Name: _____

Address: _____

Telephone: _____

ID# _____ **Group#** _____

Policy Holder Name (if different from Patient): _____

Relationship of policy Holder to Patient: _____

Prescription Drug Policy:

- Provides up to 30 days at a time
- Provides up to 90 days at a time
- No prescription drug coverage
- Mail away option for 90 days (please provide information):

Other:

Secondary Insurance:

Company Name: _____

Address: _____

Telephone: _____

ID# _____ **Group#** _____

Policy Holder Name (if different from Patient): _____

Relationship to patient: _____

A Better Alternative Medical Center

Robin Ellen Leder, M.D.
235 Prospect Avenue, Suite LB
Hackensack, New Jersey 07601
Telephone: (201) 525-1155 / Fax (201) 525-0915

Signature on File

Patient Name _____

Insurance Provider _____

Insurance ID Number _____

I, the undersigned, do hereby agree that all monies paid on my account by my health insurance provider, _____ for services rendered to me by Robin Ellen Leder, M.D. shall be made directly payable by said insurance company in the event that service paid via check are non-negotiable and cash/credit card is not available for payment.

I understand and agree that, if any monies for services rendered by Dr. Robin Leder are paid directly by my insurance company to me or a family member in the above instance, the monies shall be remitted by me to Dr. Leder immediately and in full. I shall be fully and solely responsible for this reimbursement to Dr. Leder.

I further give permission for this signature to be kept on file for any Medicare filing or other necessary paperwork requiring my signature for reimbursement.

I do so signify by the signing of my name below on this date in front of a witness.

Patient Name _____

Witness Name _____

Patient Signature _____

Witness Signature _____

Guardian Name _____

Date _____

Guardian Signature _____

Date _____

CANCELLATION POLICY

Cancellation without sufficient warning and “no-shows” play havoc with our office scheduling. Therefore, we ask that you give us a full business day’s notice (24 hours) if you must cancel and appointment. This is equally important for IV therapy, shots, and any scheduled lab testing. Many tests and procedures require extensive advance preparation, which is wasted if you miss your appointment. In the event we do not receive 24 hour notice, you will be charged one half of the normal fee the first time, and the full amount any time thereafter.

Initiating this policy allows us sufficient time to schedule another appointment and to keep the office running smoothly and efficiently.

We fully understand that life situations do arise and make it difficult or impossible for an appointment to be kept. However, in fairness to other patients who may be kept waiting for many days in order to obtain appointments, we must adopt and enforce this policy.

Whenever our time permits, we will make a call to confirm/remind you of your visit, but even if we are unable to make contact with you, you are ultimately responsible for keeping your appointment or canceling in a timely fashion.

Note: Your visit will begin at the scheduled time unless the office is running behind. If you arrive late, your visit will be billed as a full visit of the originally scheduled length. If the next patient is late as well, we will try to extend your visit to its scheduled length. To check to see if the office is running on time, or to let us know you are running on time, it is always advised that you call ahead prior to heading over. Our schedule is subject to fluctuations at any time due to the nature of the practice of medicine.

We thank you for your cooperation.

Please sign below to indicate that you have read and understand our cancellation policy.

Patient Name (Print)

Patient/Guardian Signature

Guardian Name (Print)

Date

Witness Signature

Date

HIPPA NOTICE OF PRIVACY PRACTICES

A Better Alternative Medical Center
Robin Leder, M.D.
235 Prospect Avenue
Hackensack, NJ 07601
201-525-1155

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice of privacy practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other uses required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducted or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign in sheet at the registration desk where you will be asked to sign your first name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following ways without your authorization. These situations include: as required by law, Public Health issues as required by law, Communicable Diseases, Health oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, Organ Donation, Research, Criminal Activity, Military Activity and National Security, Workers' Compensation, and Inmates Required Uses and Disclosures. Under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures such as research will be made with your consent, authorization, or opportunity to object unless required by law. You may revoke this authorization at any time, except to the extent that your physician or the physician's practice has taken action in reliance on the use or disclosure indicated in the authorization.

Your Rights: The following is a statement of your rights with respect to your protected health information.

1. Under federal law, you have the right to inspect and copy your protected health information. However, you may not inspect or copy the following records:
Psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, law that prohibits access to protected health information.

2. You have the right to request a restriction of your protected health information. This means that you may ask us not to disclose or use any part of your protected health information for the purposes of treatment, payment, or health care operations. You

may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician feels it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another healthcare professional.

3. You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us upon request, even if you have agreed to accept this notice alternatively (i.e. electronically).

4. You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

5. You may have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint.

WE WILL NOT RETALIATE AGAINST YOU FOR FILING A COMPLAINT.

This notice was published and becomes effective on or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA compliance officer in person or by phone via our main phone number.

Signature below is only acknowledgement that you have received this notice of our Privacy Practices.

Patient/Guardian Name (PRINT)

Patient/Guardian Signature

Date: _____

**IMPORTANT INFORMATION REGARDING INSURANCE COVERAGE
FOR OFFICE VISITS AND LABORATORY TESTING**

One of the most common questions that our office receives is whether or not their traditional medical insurance or Medicare will cover visits and recommended tests and/or procedures.

With the wide variety of insurance products carried by our patients, it is impossible for us to know if and to what extent the costs of a test or procedure will be reimbursed by your insurer. If this is an important concern to you, the best source of information would be your own insurance company. It is always a good rule of thumb to know your insurance well to receive maximum benefits.

In order to assist you, your insurance provider may need to get test or procedure codes to verify coverage. These code numbers, CPT codes, need to be obtained from each individual laboratory. Each test that is ordered for you will have multiple CPT codes, since each procedure is actually a panel consisting of a number of tests, and each of these has its own code. The phone number to each lab can be found on the Important Phone Number List, provided in your colored first day folder. This information will assist you in obtaining precertification of the insurer's willingness to pay for a lab test or procedure, if possible.

Often, insurers will put off this decision until after a test has been completed, and will at that time request a letter of medical necessity. Our office will make every effort to provide you with such a letter as Dr. Leder will not order testing or procedures that she does not deem medically necessary. However, it is always important to note, that even with the support of our office, insurance claims may be denied. Please keep in mind that persistence is worthwhile when dealing with insurers in an effort to obtain all rightful benefits.

After your initial visit and on subsequent visits throughout your treatment, Dr. Leder will order a number of tests to evaluate your health. Some tests will be ordered from the usual group of "reference laboratories" with which you may be familiar (Quest, LabCorp, etc...). For any tests ordered from this type of "traditional" lab, IT IS IMPERITIVE FOR YOU THAT YOU KNOW AND LET US KNOW WHICH LAB HAS/HAVE BEEN DESIGNATED BY YOUR HEALTH INSURER AS THE LAB AFFILIATED WITH YOUR PARTICULAR POLICY. In this office, we use primarily Quest, LabCorp, and BioReference. There will be a fee for the processing of your specimen if drawn at our office.

ONCE YOUR BLOOD HAS BEEN DRAWN IN OUR OFFICE AND DULY PROCESSED BY A PARTICULAR LAB, YOU WILL BE HELD RESPONSIBLE FOR THE LAB CHARGES, REGARDLESS OF WHETHER YOUR INSURER HAS SELECTED ANOTHER COMPANY FOR YOU OR NOT. AS MUCH AS WE WOULD LIKE TO ACCOMMODATE YOU, WE CAN ONLY ACCOMMODATE YOUR NEEDS IF YOU TELL US WHAT THEY ARE BEFORE YOUR BLOOD IS DRAWN.

At the end of the day, claims that are medically justified may still be denied. For this reason, you are strongly encouraged to take advantage of the pre-pay and pay-assured programs offered by many of the laboratories. Pre-pay and Pay-Assured balances may still be submitted to your insurance company for reimbursement barring any special contractual commitments. Ultimately, whether you receive reimbursement or not, these programs will allow you the benefit of paying a significantly lower and fixed rate. These rates and plans are explained more fully on the individual educational consent forms that you will receive for each specific test/procedure.

Although our office will make every effort to assist you in your dealings with your insurer, it is ultimately your responsibility to communicate with and verify benefits afforded to you. Our office is in no way associated with any insurance company and takes no responsibility for denied claims.

Patient/Guardian Signature

Witness Signature

Patient/Guardian Name (Print)

Witness Name (Print)

Date

Date

Patient Disclosure and Authorization of Information to other Physicians

As Dr. Leder's patient, you may want her to advise any additional physicians you visit of her suggested treatment approach. Upon patient request and authorization, Dr. Leder will be pleased to communicate her protocol with any other doctor(s). Please set forth below the names, addresses, telephone numbers, and fax numbers of any and all physicians with whom you wish Dr. Leder to communicate on your behalf with respect to her suggested treatment approach, or indicate below that this is *not* your wish.

Doctor's Name: _____
Address: _____
Telephone and Fax Number: _____
Condition for which they treat you: _____

Doctor's Name: _____
Address: _____
Telephone and Fax Number: _____
Condition for which they treat you: _____

Doctor's Name: _____
Address: _____
Telephone and Fax Number: _____
Condition for which they treat you: _____

Doctor's Name: _____
Address: _____
Telephone and Fax Number: _____
Condition for which they treat you: _____

() I do not request/authorize Dr. Leder to discuss her suggested treatment(s) with any other physician(s).

Patient Name _____

Witness Name _____

Patient Signature _____

Witness Signature _____

Date _____

Date _____

Patient Name: _____

Date: _____

VISITS LIMITED TO THEIR SCHEDULED TIMES AND LENGTHS

In today’s busy world, everyone is running on a tight schedule to get everything done. Waiting in our office for extended periods is a hardship for many, and doesn’t make anybody happy.

In order to accommodate each of our patients, and remain respectful of their schedules, all patient visits will be limited to their scheduled times and lengths.

To enable us to remain on schedule successfully:

- 1) **Please make sure to bring up all of the most important things you want to cover in your visit early on.** If you arrive several minutes in advance of your visit, you will be able to write these down on a form we can provide, in order to collect your thoughts. Keeping a list of concerns and questions between visits and bringing this with you can also be quite helpful.
- 2) **If you arrive late for your visit,** you will be billed for the full booked visit. The visit will end as originally scheduled.
- 3) If you are encountering scheduling problems during the day, please call to let us know. We may be able to rebook you later in the day or switch your appointment with another patient. Try to avoid a cancellation fee or paying for lost time, it is worth a call.
- 4) **Book a visit of adequate length.** Two 25 minute visits are more costly than one 50 minute visit.
- 5) You will be advised during your appointment when we have 5 minutes left to talk. This is a courtesy to allow you and the doctor to wrap up your most important thoughts, prescription requests, or whatever cannot wait until the next visit.
- 6) If our schedule permits, and you do require additional time up to 50 minutes, we will extend your visit if possible.
- 7) Try to leave enough time to be here a few minutes early, in case of unexpected traffic. Ask for a cup of herbal tea and relax for a moment before you enter your visit.
- 8) **Emergencies can arise in a medical office.** Please call prior to leaving for your visit to make sure that we are running true to schedule. If there is a special problem delaying us more than 30 minutes, we can accommodate you with a new appointment if you wish.

After nearly 20 years in practice, we find that staying on time is one of the very most important concerns for our patients. We thank you so much for your cooperation with this policy, and hope that you will enjoy the benefit of knowing that your visit will begin as scheduled. If you have any suggestions as to how was can improve yet further, we would love to hear from you.

I understand this policy and am willing to work with A Better Alternative Medical Center adhering to these guidelines.

Patient Name

Date

Patient Signature

Witness Signature

Robin Ellen Leder, M.D.

A Better Alternative Medical Center

Robin Leder, M.D.
235 Prospect Avenue
Hackensack, NJ 07601
201-525-1155

What would you like to accomplish together?

A complete nutritional program often includes changes in diet, habits, exercise patterns, and taking vitamins or supplements prescribed by the physician. Please answer the following questions as openly as possible so the doctor can devise a plan that best suits your needs and lifestyle.

My greatest concerns about my health (**my health goals**) are:

Are you concerned with or **interested in taking vitamins and supplements** as prescribed to maintain and/or improve your health?

Do you want to **improve your energy** level?

Do you want to improve any **specific health problem(s)**?

Would you like to reduce or possibly **eliminate your current medications**?

Are you willing to **lose weight and/or change your diet** if it will help you achieve your goals?

Please check the following boxes as they apply to you:

Would You Like To?	Definitely Interested	Need More Info.	Not Interested	This Does Not Apply to Me
Lose Weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gain Weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stop Smoking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reduce Alcohol Intake	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Improve Your Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Improve Your Energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Improve Your Concentration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Improve Your Moods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reduce Contraction/Duration of Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PATIENT CONCENT FORM

The Department of Health and Human Service has established a "Privacy Rule" to help insure that personal health care information is protected for

privacy. The Privacy Rule was also created in order to provide a standard for certain healthcare providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry our treatment, payment, or healthcare operations.

As our patient, we want you to know, that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we can provide the minimum necessary information to only those we feel are in need of your healthcare information and information about treatment, payment or healthcare operations, in order to provide healthcare that is in your best interest.

We also want you to know that we support your full access to your personal medical records. WE may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment or healthcare operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose Your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request or refuse your entire PHI. You may not revoke actions that have already been taken which relied on this or previously signed consent.

If you have any objections to this form, ask to speak to our HIPPA compliance officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name: _____ Signature: _____ Date: _____

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To our valued patients:

The misuse of personal health information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers, and doctors continually undergo training so that they may understand and comply with government regulations regarding the Health Insurance Portability and Accountability Act (HIPPA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate uses of PHI in accordance with the governmental rules, laws, and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of the fact, our policy is to listen to our employees and patients without any thought of penalization if they feel that an event in anyway compromises our policy of integrity. More so, we welcome your input regarding any service problems so that we may remedy the situation promptly. Thank you for being one of our highly valued patients.

Many people who come to our office say that they had a difficult time locating a physician in this area who practices alternative medicine.

In an effort to find out how best to let people know about our office and the services that exist, we ask that you fill out this brief questionnaire fully. Thank you for your help.

HOW DID YOU HEAR ABOUT OUR OFFICE?

Referral from a friend, co-worker or relative

Friend's Name: _____ Relationship: _____

Referral from a doctor Doctor's Name: _____

Specialty: Nutritionist Psychotherapist
 Podiatrist Health/Life Coach
 Chiropractor Dentist

Referral from a gym Name: _____

Referral from a health food store Name: _____

Yellow Pages Book Used (Bergen, Passaic, etc.): _____

Category Searched: Holistic Center Nutrition Physicians

New Jersey Naturally Category Searched: Holistic Center Chelation Therapy
 Physicians Other

Internet

Dr. Leder's Website

Organization Website

ACAM AHMA A4M AAEM ICIM Arthritis Trust

Laboratory Website

Spectracell

IMMUNO

Neuroscience

Meta Metrix

Genova

Other Site

Radio Advertisement _____ Other _____

ROBIN ELLEN LEDER, M.D.
235 PROSPECT AVENUE
HACKENSACK, NJ 07601

PATIENT PRIVACY PROTECTION

TO WHOM IT MAY CONCERN:

I specifically direct the above not to copy or release any medical or health related information, records, history, or data to any person, including local, state, and/or federal government agencies without my express and specific written permission with each such request.

If I am legally declared incompetent or if I am physically unable to do so, consent may be given, in writing, by my heirs or assigns to release and access above.

NAME: _____
(Print Patient Name)

ADDRESS: _____
(Print Patient Address)

CITY/STATE/ZIP: _____
(Print Patient Address)

SIGNATURE: _____
(Patient Signature)

WITNESS: _____
(Witness Signature)

DATE: _____
(Date Patient and Witness Signed)

Important information to our Medicare patients regarding:
SUBMITTAL OF CLAIMS TO MEDICARE by the office of Dr. Robin Ellen Leder

As a very small practice, our office is permitted to submit Medicare patient claims through the mail on paper. At this point, we have chosen this option as opposed to electronic submittal, as it is far more cost effective for a very small office such as ours to use this approach, and our limiting administrative costs translates into our being able to contain the cost of services to our patients.

Also, to streamline our effort to submit your claims promptly, we ask that, on each date of service in our office, you fill out a Medicare form (red carbon copy-carrying HCFA form) according to the sample provided to you in your first day folder. If you are unable to fill this out because of disability, ask someone how to proceed. One filled out form is required for each submittal. After you have filled out the top of the sheet, we will enter the office information on the bottom and can submit promptly on the date of service. Your failure to supply us with a filled out form will inevitably lead to delays in submitting your claim and hence in your receiving your just reimbursement.

Paper submittals may not be processed as quickly as electronic claims, and are occasionally misplaced or lost to the system. It is unfortunately not unheard of for us to submit a claim, and discover later that Medicare has never entered the claim into their system. If you are waiting for reimbursement on a Medicare claim, you:

- Need to be aware of the possible delays that may occur
- Should not hesitate to contact Medicare if you have waited at least six weeks to hear about a claim, and have heard nothing
- Should make sure after six weeks that the claim has at least been entered into the system
- Should inform our office if the mailed claim has in fact not been entered into the system, so that we may resubmit it

Medicare informs us of any irregularities or inadequacies of our claims, if any, but they are not in a position to detect a failure of the claim to reach their office or to be entered appropriately by them into the system, NOR do we have the facility to know if a claim has gone unattended to or simply has not been received. **To maximize your reimbursement, you need to be on top of all claims, just as with a private insurer.** If you let us know of a problem, we can assist you.

Like other insurance claims, **Medicare claims are time-sensitive**, so do not wait months or years to let us know that a claim is not getting reimbursed. Timely submittal may be all that is required to get the payment you deserve.

If your Medicare claims are processed through other than the usual New Jersey Medicare channels and address, please give us the proper name and address of the Medicare provider who handles you.

I have read the above information regarding submittal of Medicare claims by the Doctor's Center for Health and Healing, and have understood it and my role as a patient in this context in obtaining all reimbursement due me.

Patient of Guardian Signature

Date

Patient Name

Witness

Guardian Name

INDIVIDUAL PATIENT HEALTH FLOW CHART

Patient Name: _____

Date of Birth: _____

Allergies: _____

Please list all of the medications you are now taking:

Medication	Date Begun	Dosage	Symptoms

Please list the most recent dates you received each of the services listed below:

Full Physical				
EKG				
Office Breast Exam				
Breast Self Exam				
Mammogram				
Pap Smear (Female)				
PSAG/PAP (Male)				
Full Bloodwork				
Urinalysis				
Hemoccult				
Sigmoidoscopy				
Chest X-Ray				
TB Test				
Eye Exam (Diabetics)				

Robin Ellen Leder, M.D.

A Better Alternative Medical Center

235 Prospect Avenue, Suite LB

Hackensack, New Jersey 07601

STATEMENT OF OFFICE POLICY

Please read all of the following statements regarding our office policy and initial each as marked by "X" to indicate that you have read and understood each paragraph:

1. **LAB TEST REVIEW:** The standard procedure at A Better Alternative Medical Center is for patients to review all tests results during a scheduled office visit with the ordering physician. The review is not handled by telephone.

Patient's Initials: X _____

2. **ADDITIONAL PRIMARY CARE PHYSICIAN:** Alternative medicine is not a hospital-based, nor an emergency care specialty. For this reason, you may find it convenient to maintain an ongoing relationship with a local Internist or other traditional physician while you are being treated at this center. In addition if at any time, Dr. Leder feels that your problem imminently requires diagnosis or care from a traditional specialist, you will be so advised and are strongly urged to follow any such advice.

Patient's Initials: X _____

3. **IN CASE OF EMERGENCY:** In the event of any medical emergency, we request that you contact both this office and any local physician with whom you are in contact, and then proceed directly to a local emergency facility for immediate attention. We will contact you as soon as possible, and will gladly work with any physician or facility of your choosing, to the extent that they are willing to accept guidance and/or assistance in the area of nutritional/complementary medicine. In our experience, this willingness will vary greatly from doctor to doctor.

Patient's Initials: X _____

4. **TELEPHONE CALLS:** Barring technical difficulties, a message machine should be available to receive your calls 24 hours a day. Messages are picked up at regular intervals, generally at least once daily and returned as soon as possible. The phone is best reserved for scheduling appointments and asking brief, individual, and well defined questions. If, during the week, you notice a change in symptoms, it is appropriate to schedule an office visit as soon as possible. If you have a number of questions about your diet, your progress, your program, etc, it is most useful to write the questions down as they occur to you, and arrange an appointment to cover them all in one visit. Using the phone in this limited fashion will assist the doctor in remaining on time for scheduled visits, both yours and those of other patients. Your cooperation is greatly appreciated.

Patient's Initials: X _____

5. **PAYMENT IN FULL ON DATE OF SERVICE:** Each of your visits, including today's visit, need to be paid in full on the date on which services are rendered. We accept **Visa and Mastercard only**, as well as checks backed with credit card information. We do not have the necessary billing manpower to offer extended payment plans or deferred billing, but the use of a credit card can afford you additional time to pay you office bills.

Patient's Initials: X _____

6. **FORMAT OF VISITS:** Your first visit and all subsequent visits are billed based upon the length of time you spend with the doctor. The material covered in each visit varies considerably from patient to patient, but typically the first visit covers a detailed history/intake, the second a physical exam, any additional

history not covered in the initial consultation, and the formulation of a testing plan. The next visit then covers a review of test results and the development of an initial treatment protocol. During ongoing visits, the protocol is monitored and further testing or treatment is implemented. For medical, ethical, and legal reasons, treatment protocols and/or prescriptions cannot and will not be given to any patient until an evaluation, including history, physical, and lab work has been completed and reviewed.

Patient's Initials: X_____

7. **BILLING BASED ON LENGTH OF VISIT:** Your office visits are billed according to the time spent with the doctor, beginning when you enter the office, and ending when your conversation with the doctor ends. Initial and completion times are recorded in your chart for each visit. This information is important in supporting your insurance claims. Time is carefully monitored by the front desk. In the event that the visit is interrupted by a phone call or emergency, timing is topped until you work with the doctor resumes.

Patient's Initials: X_____

8. **IF WE ARE RUNNING LATE:** As much as we always make the effort to stay on schedule, the human factor often leads to unexpected schedule variations during the day. Please allow some flexibility in your own schedule on days of appointments. You may also wish to call us before you leave for the office to see if we are running true to schedule. If we are running **more than 30 minutes** behind schedule, and you are therefore unable to stay until the end of your scheduled visit, please let us know **before** you begin your visit. If informed of your concerns, we can offer you several options to accommodate your needs: rescheduling, breaking up the visit, doing an abbreviated visit, or finishing your visit by phone. If we are late and you wish to do your visit as planned, barring unusual circumstances, we will make every effort to provide a visit of the originally scheduled length.

Patient's Initials: X_____

I, the undersigned, have read, fully understand and acknowledge the preceding statements regarding the **OFFICE POLICY of A Better Alternative Medical Center**, and agree to be treated in accordance and in cooperation with the above stated policies.

Patient Signature

Date

Patient Name (printed)

Witness Signatue

Date