Fieve Psychiatry Center
Ronald R. Fieve, M.D., P.C. and Associates
587 Fifth Avenue #802
New York, New York 10017
Phone (212) 249-1600
Fax: (212) 288-0809

PLEASE READ THE FOLLOWING INFORMATION BEFORE FILLING OUT YOUR FORMS:

We look forward to serving you at our practice. Before filling out the attached forms, we would like to advise you of the requirements to accept you as a patient in our practice.

1. **You MUST provide a copy of the front and back of your insurance card**
2. **You MUST include a Photo ID with your forms**
3. **You MUST include a copy of the front and back of the credit card(s) you are putting on file. Please note a major credit card is required to be a patient at our practice. If you would like to use an HSA or FSA card for payments, please also send a copy with your application and additionally fill out this information in the appropriate areas. There are NO EXCEPTIONS to this requirement.**

Please make sure to read all financial responsibility forms within your packet. Our Late Cancellation and/or No Show policy is important to read so you know what the requirements are. Please understand this policy is taken very seriously since we reserve the time for you and never overbook appointments.

All attached forms must be filled out in full. If you do not wish to provide any or all information or refuse to fill out any portion of the forms, we cannot accept you as a patient in our practice.

Please note that if all information above is not received with your patient forms, your appointment request WILL NOT be processed, and your forms will not be reviewed.

If you should have any additional questions, please call our office for assistance.

Thank you,

Paula Puia
Director of Operations

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Date: _____ **Appt Date: _____ @_____**

Personal Information:

Patient Name: _____ **Phone:** (Home) _____

Address: _____ Apt: _____ (Cell) _____

City: _____ State: _____ Zip: _____ (Work) _____

Date of Birth: _____/_____/_____ **Private SMS Messages Allowed YES** Email: _____

ARE YOU EMPLOYED? Yes No If yes, employer name: _____

Sex: Male Female Other: _____**Marital Status:** (Circle One) Single Married Divorced Other:_____

Insurance Information: PRIMARY

Insurance Company Name: _____ ID #_____ Group#: _____

Name of Insured: _____ Relation: _____

Specialist Co-Pay Amount: $_____ ***Authorization#:*** **_____** ***Visits Authorized:*** **_____**

Effective Date of Authorization: **_____** ***to*** **_____**

SECONDARY

Insurance Company Name: _____ ID #_____ Group#: _____

Name of Insured: _____ Relation: _____

Specialist Co-Pay Amount: $_____ ***Authorization#:*** **_____** ***Visits Authorized:*** **_____**

Effective Date of Authorization: **_____** ***to*** **_____**

How did you hear about us? _____

Primary Care Physician: _____ Phone #_____

Pharmacy Name: _____ Address: _____ Phone# _____

Emergency Contact:

Name: _____ Phone (1): _____

Relationship: _____ Phone (2): _____

Patient Name: _____ **Date: _____**

Medical History

Please complete the following questions to the best of your ability:

Brief Statement of your complaint:

_____

_____

_____

_____

Number of past psychiatric hospitalizations? _____ Where? _____

Age of onset of first depression or manic episode? _____

Are you currently seeing another psychiatrist? Y N

If so: Name of current psychiatrist? _____Phone#: _____

Please list all conditions you are currently being treated for:

_____

_____

Please list any and ALL current medications including psychiatric medications:

_____

_____

_____

_____

Please list any allergies and medications you are allergic to:

_____

Have you had any of the following?

Suicidal thoughts Y N

Suicidal Attempts Y N

Drug abuse Y N If yes, please list type of drugs: _____

Alcohol Abuse Y N If yes, please list details: _____

Recent weight loss Y N If yes, how much _____

Recent weight gain Y N If yes, how much _____

Have you had a Physical Exam in the last six months? (Please circle) Y N

If Yes, Doctor who performed exam? _____ Date: _____

(If physical was performed more than six months ago, a new exam is required.)

FOR WOMEN ONLY: Are You Pregnant: ___ YES ___ No. If No date of Last Menstrual Cycle: _____

Patient Name: _____ **Date: _____**

Family History

Has anyone in your family had any of the following?

1. Arrests? Y N relationship: _____

2. Any outburst or antisocial behavior? Y N relationship: _____

3. Psychiatric Hospitalizations? Y N relationship: _____

4. Depression? Y N relationship: _____

5. Suicide? Y N relationship_____

6. Drug Abuse? Y N relationship _____

7. Alcohol Abuse? Y N relationship _____

8. Excessive Spending? Y N relationship _____

Please place a check mark beside any of the following symptoms or problems if you have experienced them recently or have concerns about them. If you don't understand something, place a question mark by it. Your doctor will discuss any positive responses with you.

A. General:
- ☐ Fevers, chills or sweat
- ☐ Recent loss of appetite
- ☐ Fatigue
- ☐ Recent unexpected weight loss

B. Eyes:
- ☐ Blurred or double vision
- ☐ Eye pain or irritation
- ☐ Eye discharge
- ☐ Eye pain
- ☐ Failing vision
- ☐ Sensitivity to light

C. Ears, Nose, Throat
- ☐ Earache
- ☐ Ringing in ears
- ☐ Decreased hearing
- ☐ Difficulty swallowing
- ☐ Frequent nose bleeds
- ☐ Frequent sore throat
- ☐ Prolonged hoarseness
- ☐ Sinus trouble or congestion

D. Cardiovascular:
- ☐ Chest pain
- ☐ Fainting spells
- ☐ Palpitation (fast, irregular heart)
- ☐ Shortness of breath with exertion
- ☐ Swollen ankles

E. Respiratory:
- ☐ Chronic cough
- ☐ Chronic shortness of breath
- ☐ Chronic wheezing
- ☐ Coughing up blood
- ☐ Excessive phlegm

I. If you are a woman:
- ☐ Unusual vaginal discharge
- ☐ Loss of control of your urine
- ☐ Painful urination
- ☐ Blood in urine
- ☐ Increased frequency of urination
- ☐ Have your periods stopped?
- ☐ Do you have excessive flow, pain, or other menstrual symptoms that disrupt your life?
- ☐ Genital sores
- ☐ Nipple discharge
- ☐ Breast mass or tenderness
- ☐ Desires discussion on HIV
- ☐ Desires Hormone Replacement Therapy
- ☐ Desires Birth Control

J. If you are a man:
- ☐ Painful urination
- ☐ Blood in urine
- ☐ Increased frequency of urination
- ☐ Urinating more than twice a night
- ☐ Loss of control of your urine
- ☐ Difficulty getting or maintaining an erection
- ☐ Decreased desire for sexual intercourse
- ☐ Desires discussion on HIV

K. Musculoskeletal:
- ☐ Back pain
- ☐ Joint pain
- ☐ Swelling in joints
- ☐ Muscle cramping
- ☐ Muscle weakness
- ☐ Muscle stiffness
- ☐ Arthritis

F. Gastrointestinal:
- ☐ Persistent nausea/vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Change in appearance of stool
- ☐ Chronic abdominal pain
- ☐ Bloody or very black stool
- ☐ Jaundice (yellow skin)

G. Skin:
- ☐ Skin rashes
- ☐ Itching
- ☐ Chronic dry skin
- ☐ Suspicious moles or other skin abnormalities you are concerned about

H. Neurologic:
- ☐ Headache
- ☐ Unable to move parts of your body at times
- ☐ Weakness
- ☐ Numbness/tingling sensations
- ☐ Seizures/convulsions
- ☐ Fainting spells
- ☐ Tremor/hands shaking
- ☐ Dizziness/vertigo

L. Psychological:
- ☐ Feeling depressed, sad
- ☐ Memory loss
- ☐ Difficulty concentrating
- ☐ Phobias/unexplained fears
- ☐ No pleasure in life anymore

M. Endocrine:
- ☐ Cold or heat intolerance
- ☐ Excessive appetite
- ☐ Excessive thirst and urination
- ☐ Significant weight change

N. Heme/Lymphatic:
- ☐ Excessive bruising or bleeding
- ☐ Swollen glands in neck, armpits, or groin

O. Allergic/Immunologic:
- ☐ Hives
- ☐ Hay fever
- ☐ Getting lots of infections

P. Anything else you want your doctor to be aware of?

……..

……..

……..

Fieve Psychiatry Center
Ronald R. Fieve, M.D., P.C. and Associates

Patient Name: _____ **Date:** _____

PATIENT HEALTH QUESTIONNAIRE- 9(PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**than half the days**	**every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or	0	1	2	3
7. Trouble concentrating on things, such as reading the	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING *0* **+** _____ **+** _____ **+** _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

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Treatment Consent

1. I, _____, consent to psychiatric evaluation and treatment by Fieve Psychiatry Center and its associates. I understand that he does not, and cannot, guarantee any specific results. I understand that his ability to help me/patient depends on the completeness and accuracy of the information provided to her and compliance with her specific treatment recommendations.

2. I consent to the exchange of information, such as diagnoses, medications prescribed, medical records, and diagnostic test results, between Fieve Psychiatry Center and its associates, hospitals, and other treating professionals when necessary to facilitate treatment. Otherwise, I understand that psychiatric records are confidential and privileged and will not be released to anyone without proper written authorization, unless legally required.

3. I consent specifically to the exchange of information, both for Fieve Psychiatry Center and its associates to provide and to receive information including diagnoses, medications prescribed, medical records, and diagnostic test results from the following individuals and providers:

Y N Spouse/Partner/Significant Other: _____Phone:_____

Y N Therapist: _____Phone:_____

Y N School counselor: _____Phone:_____

Y N Primary Care Physician: _____Phone:_____

Y N Other Medical Specialists: _____Phone:_____

Y N Other Medical Specialists: _____Phone:_____

Y N Other (please specify):_____Phone:_____

Y N Other (please specify):_____Phone:_____

4. I consent to the release to any third party payer or its agents any information necessary for the processing of a claim for services rendered. Should hospitalization be required, I consent to the release of any information needed for utilization review. Should prior authorization of outpatient treatment or prescription drugs be required, I consent to the release of any information needed.

5. I have read and agree to the terms of Ronald R. Fieve, M.D., P.C.'s Office and Payment Policies. I understand that I am financially responsible for all charges, and that payments are due at the end of each session. I understand that I personally must pay the regular fee for the time reserved for any appointment which I miss without 24 hours' notice. I also understand that my insurance cannot be billed for a missed appointment and I will be solely responsible for the charge.

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6. The undersigned agrees, whether he or she signs as guardian, agent or as patient, that in consideration of the services to be rendered to the patient, he or she hereby individually obligates himself or herself to pay the account of the physician. Should the account be referred to an attorney or outside agency for collection, the undersigned shall pay reasonable attorney's fees and collection expense.

7. This consent is subject to revocation at any time, by written request, except to the extent that action has been taken in reliance thereon.

8. Explanation and acknowledgement of Treatment Decisions: The patient and/or their guardian have the authority to consent to treatment decisions. In making these decisions it is necessary to listen carefully to the opinion of the treating physician. In all medical decisions, no one has any total ability to predict the future. All decisions are based upon a weighted decision comparing the risks of treating vs. not treating. Untreated or inadequately treated illnesses may sometimes have complex and far reaching effects. Conversely, any treatment that may have desirable effects may also have undesirable side effects as well. Since everyone is different, various treatments may have a therapeutic or undesirable side effect in different individuals. Studies are performed to assess safety, tolerability and therapeutic effects in a significant number of patients. Since no two people are exactly the same, no prior study can totally predict a response in any given individual. Occasionally some side effects are evident only after many have been treated for long periods of time. There are many sources of information, some being more reliable than others. In considering treatment options and consenting to treatment decisions, feel free to investigate all sources of information. One source of medical information is the peer reviewed medical literature, some of which is available through the National Library of Medicine at http://www.ncbi.nlm.nih.gov Other sources of information include consulting other physicians or practitioners, the Physician's Desk Reference, the FDA, the Internet and various media outlets. It is important to note that most medical knowledge is yet to be discovered, and there is a considerable amount of conflicting information within the current medical literature and other sources of information.

For a variety of reasons, there has been an increasing motivation for individuals and groups to impact the physician patient relationship. This has sometimes resulted in a variety of media reports, insurance company policies, bureaucratic obstacles, privacy intrusions and various high profile lawsuits. It is suggested all this information be approached in a manner which recognizes the potential bias from each source in an effort to maintain scientific objectivity.

You have the ultimate authority in making decisions regarding your health. Open communication with your treating physician regarding beneficial as well as undesirable effects is encouraged to help achieve a better outcome.

Patient's name: _____

Signature of patient: _____

Signature of parent/guardian: _____

Date: _____

Witness: _____

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TELEMEDICINE PATIENT CONSENT FORM

Patient Name: _____ Date of Birth:_____

1. **PURPOSE:** The purpose of this form is to obtain your consent to participate in temporary telemedicine services in connection with the following procedures: New Patient Consultations, Medication Management, Follow-up Services and Psychotherapy Services.
2. **NATURE OF TELEMEDICINE CONSULT:** During the telemedicine consultation:
   a. Details of your medical history, details of psychiatric history and other examinations and test results may be discussed with you and other authorized persons, if necessary, using Interactive video, audio and telecommunication technology.
   b. A physical and mental examination of you will take place.
   c. A non-medical technician may be present in the telemedicine studio to aid in the video transmission.
   d. Video, audio and/or photo recordings may be taken of you during the service.
3. **MEDICAL INFORMATION & RECORDS:** All existing laws regarding your access to medical information and copies of your medical records apply to these telemedicine services. Please note, identifiable images or information for this telemedicine interaction to researchers or other entities shall not occur without your consent.
4. **CONFIDENTIALITY:** Reasonable and appropriate efforts have been made to eliminate and confidentiality risks associated with the telemedicine service and all existing confidentially protections under federal and New York law apply to information disclosed during this telemedicine consultation.
5. **RIGHTS:** We or You may withhold or withdraw consent to the telemedicine services at any time without affecting your right to future care or treatment, or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.
6. **FINANCIAL RESPONSIBILITY:** You understand that our office will be billing your insurance for these services. **You understand that you are still responsible to pay any co-pays, co-insurances or deductibles prior to your session start PLUS a 3% nonrefundable credit card service transaction fee.** We do not bill for copays, coinsurances or deductibles. If your card declines, you will also be responsible for an admin fee of $25 per transaction. We may put an authorization hold on your card for the responsibility amount. If your insurance refuses to pay for your services, you understand that you will be held responsible for the balance due. We have received temporary authorization from your insurance carrier to perform these services. It is your responsibility to check with your insurance carrier that you are covered for these services. Upon your insurance receiving our billing it is up to them to then pay or deny your session(s).
7. **DISPUTES:** You agree that any dispute arriving from the telemedicine service will be resolved in New York, and that New York law shall apply to all disputes.
8. **CANCELLATION REQUIREMENTS:** You understand that you must give at least 24 hours' notice to cancel or change your telemedicine session. You understand that if you do not give at least 24 hours' notice you would be responsible for the full price of the session which may range from $250 TO $350. Cancellations are NOT billable to insurance. Please call and leave a message at (212) 249-1600 or email us at staff@fieve.com so we have a timestamp of your cancellation.
9. **RISKS, CONSEQUENCES & BENEFITS:** You have been advised of all potential risks, consequences, and benefits of telemedicine. You understand all information above. You have the opportunity to ask questions about the information presented in this consent prior to your session. All questions have been answered and by signing below you understand the written information provided.

I agree to participate in telemedicine services for the above listed purposes. I understand that this may be temporary service being offered by Ronald R Fieve, MD PC and Associates and they may withdraw this service at any time.

Signature _____ Date: _____ Phone: _____

Please charge the below card for all Telemedicine co-pays, co-insurance and deductibles if any plus a 3% transaction fee:

Major Credit Card (REQUIRED)	**HSA/FSA Cards (OPTIONAL)**
☐ **Visa** ☐ **MasterCard**	☐ Visa ☐ MasterCard
☐ **Amex** ☐ **Discover**	☐ Amex ☐ Discover
Cardholder Name_____	Cardholder Name_____
Credit Card Number_____	Credit Card Number_____
Billing Address _____	Billing Address _____
City, State, Zip _____	City, State, Zip _____
Relationship to Patient _____	Relationship to Patient _____
Phone # _____	Phone # _____
Exp. Date _____ / _____ CVV _____	Exp. Date _____ / _____ CVV _____
☑ I AGREE TO TERMS AND AUTHORIZE MY CARD TO BE CHARGED	☑ I AGREE TO TERMS AND AUTHORIZE MY CARD TO BE CHARGED
Cardholder Signature: _____	Cardholder Signature: _____
***** PLEASE SUPPLY OFFICE STAFF WITH FRONT/BACK COPIES OF CARDS and ID *****	***** PLEASE SUPPLY OFFICE STAFF WITH FRONT/BACK COPIES OF CARDS and ID *****

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Patient Name: _____ Date of Birth: _____

Financial Obligation for No Show and Late Cancellation Appointments

In order to provide the best service and availability to our patients, we ask that you notify us at least 24 hours in advance when cancelling an appointment. You will be responsible for the full amount of your visit ($250-$350) if you do not call/email at least 24 hrs in advance of your appointment or do not show for your appointment. Your insurance company cannot be billed for a missed appointment. I understand and authorize my credit card below to be charged for late cancellations or no show missed appointments.

Signature of Patient _____ Date: _____

AUTHORIZATION TO CHARGE CARD

By signing this Credit Card Authorization form, I authorize Dr. Ronald R. Fieve, MD, PC to utilize this form as an authorization to charge the below credit card for current outstanding balances/charges including copays, coinsurance, deductibles, denied charges, missed appointments, late cancellations and phone consultations, plus a 3% nonrefundable service transaction fee. I understand that this authorization will remain in effect until I cancel it in writing. I understand my insurance company does not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of my Insurance policy at time of service. I understand if my claim(s) are denied I am fully responsible for all charges and authorize the below credit card to be charged for not covered services. I also understand that this card may be charged for late cancellation and/or no show appointments. I also understand that if my card is declined, I am subject to 3% interest compounded monthly on any unpaid charges. I may also be asked to put a retainer on file for one year in order to make future appointments. I authorize a prior auth be placed on my card for $50.00 for each scheduled appointment to make sure my card is valid. An admin fee of $25 is due if payment for copays, deductibles or coinsurance is not paid at time of service.

CREDIT CARD BILLING INFORMATION (ALL INFO MUST BE INPUTTED)

Major Credit Card (REQUIRED)	**HSA/FSA Cards (OPTIONAL)**
☐ **Visa** ☐ **MasterCard**	☐ Visa ☐ MasterCard
☐ **Amex** ☐ **Discover**	☐ Amex ☐ Discover
Cardholder Name_____	Cardholder Name_____
Credit Card Number_____	Credit Card Number_____
Billing Address _____	Billing Address _____
City, State, Zip _____	City, State, Zip _____
Relationship to Patient _____	Relationship to Patient _____
Phone # _____	Phone # _____
Exp. Date _____ / _____ **CVV** _____	Exp. Date _____ / _____ CVV _____
☑ I AGREE TO TERMS AND AUTHORIZE MY CARD TO BE CHARGED	☑ I AGREE TO TERMS AND AUTHORIZE MY CARD TO BE CHARGED
Cardholder Signature: _____	Cardholder Signature: _____
***** PLEASE SUPPLY OFFICE STAFF WITH FRONT/BACK COPIES OF CARDS and ID *****	***** PLEASE SUPPLY OFFICE STAFF WITH FRONT/BACK COPIES OF CARDS and ID *****

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ Date of Birth:_____

Address:_____

Ronald R. Fieve, MD, PC:

I have been given a copy of Ronald R. Fieve, MD, PC's *Notice of Privacy Practices ("Notice*"), which describes how my health information is used and shared. I understand that Ronald R. Fieve, MD, PC has the right to change this *Notice* at any time. I may obtain a current copy by contacting the Facility Privacy Official, or by visiting the Ronald R. Fieve, MD, PC web site at www.fieve.com.

My signature below acknowledges that I have been provided with a copy of the *Notice of Privacy Practices:*

_____ _____
Signature of Patient or Personal Representative Date

_____
Print Name

_____
Personal Representative's Title (e.g., Guardian, Executor of Estate, Health Care Power of Attorney)

For Facility Use Only: Complete this section if you are unable to obtain a signature.

If the patient or personal representative is unable or unwilling to sign this *Acknowledgement*, or the *Acknowledgement* is not signed for any other reason, state the reason:

_____

_____

Describe the steps taken to obtain the patient's (or personal representative's) signature on the *Acknowledgement:*

_____

_____

Completed by:

_____ _____
Signature of Facility Representative Date

Print Name _____

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Treatment Plan

For your treatment to be successful, it is very important that you make a commitment to our practitioners on a consistent and on-going basis. This requires adherence to the following treatment plan to be treated at our practice. This is just an example of the treatment plans available. Your custom plan will be discussed with you with your practitioner which may include weekly or biweekly appointments.

- **Monthly visits are required to be a patient at our practice. If receiving 90-day supply of medication you must still check in monthly. If you do not adhere to this policy, you will be terminated from care.**

- **If you are planning to file for disability or leave from work, you will be required to schedule weekly sessions.**

Yearly Physical Requirements

It is required as a **New patient** and/or **Existing patient** that you obtain a yearly **Physical, EKG and Bloodwork** depending on the type of medication you are prescribed. This is an important part of your medical care. This is to ensure proper medication monitoring no matter what type of prescription you are prescribed from our office. **ALL** testing must be performed to continue prescribing you medication. No Exceptions. This requirement will be discussed with your practitioner during your visit. A list will be provided upon request.

_____ _____ _____

Patient Name **Patient Signature** **Date**

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Insurance Assignment of Benefits Form

I, _____, understand that services rendered to me by Ronald R Fieve, MD, PC and Associates are my financial responsibility and that the provider will bill my insurance company _____, as a courtesy. I authorize my insurance company to pay my benefits directly to Ronald R Fieve, MD, PC and Associates and I understand that I will be fully responsible for any outstanding balance on my account. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee and I haves agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

I have been given the opportunity to pay my estimated deductible and coinsurance at the time of service.
I have chosen to assign the benefits, knowing that the claim must be paid within all state or federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the prompt payment of the claim by _____(INSURANCE COMPANY).

I authorize the provider to release any information necessary to adjudicate the claim, and understand that there may be associated costs for providing information beyond what is necessary for the adjudication of a clean claim.

I also understand that should my insurance company send payment to me, I will forward the payment to Ronald R Fieve, MD, PC within 48 hours. I agree that if I fail to send the payment to Ronald R Fieve, MD, PC and they are forced to proceed with the collections process; I will be responsible for any cost incurred by the office to retrieve their monies. In the event patient receives any check, draft, or other payment subject to this agreement, I will immediately deliver said check, draft, or payment to provider. Any violations of this agreement will, at provider's election, terminate patient charge privileges with provider and bring any balance owed by patient to provider immediately due and payable.

To avoid this additional cost and inconvenience, should the insurance company forward payment to me, I authorize Ronald R Fieve, MD, PC to facilitate payment utilizing the credit card number on file to resolve the balance. A photocopy of this Assignment shall be considered as effective and valid as the original.

I authorize Ronald R Fieve, MD, PC to initiate a complaint or file appeal to the insurance commissioner or any payer authority for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials.

Dated : _____

_____ _____
Witness Signature of policyholder Patient or Guardian