# Welcome!

Our mission is to provide outstanding care in a pleasant and efficient setting. We respect your time and appreciate the privilege and trust of participating in your health care. In order to ensure that patients will be seen in a timely fashion, and that our physicians' time is respected as well, we have the following office policies:

**There is a no-show fee/late fee**. If an appointment is made and I do not call more than 24 hours in advance to cancel/reschedule, or if I am more than 15 minutes late, then I will be charged **$25**. For evening (after 4 pm) & Saturday appointments, the no-show fee is **$50**. For surgical procedures, the no-show fee is **$100. I have read and understand the above policy**.

_____ _____

**Name** **Date**

**I hereby assign insurance payment to be made to Dr. Ilan Cohen & Dr. Krishna Morar, for services rendered.**

a. If my insurance plan requires that I obtain a **referral** from my Primary Care Doctor (internist, family practitioner or pediatrician), then **it is my responsibility** to obtain this referral.
b. I understand that I am responsible for co-payments, unmet deductibles, co-insurance fees, bounced check fees and no-show fees.
**c.** **If, for any reason, my insurance plan does not pay for services rendered by Dr. Ilan Cohen & Dr. Krishna Morar, or for any part of the services rendered, then it is my responsibility to pay for any and all non-covered services.**
**d.** If I default on the above responsibilities, I understand that I will be held responsible for *any and all* costs associated with collecting my debt, including court costs, collection fees and a **$200** administrative fee if a court action is commenced.

**I have read and understand the above policies.**

_____ _____

**Name** **Date**

**HIPAA Acknowledgement**

I have received a copy of Dr. Ilan Cohen & Dr. Krishna Morar's Notice of Privacy Practices.

**Signed**: _____ **Date**:_____

**Non-covered services**

It is my understanding that my insurance plan **may not** pay for certain services provided by Dr. Ilan Cohen & Dr. Krishna Morar. I have been informed of this by Dr. Ilan Cohen & Dr. Krishna Morar and agree to pay for these uncovered services as follows:

****Refraction** (measurement for glasses and eyeglass prescription): **$40**

****Contact Lens Fitting** **$75 and up**

**Signed: _____ Date: _____**