"SIGNATURE ON FILE"

ROBIN ELLEN LEDER, M.D.
235 PROSPECT AVENUE
HACKENSACK, NJ 07601
(201) 525-1155

_____
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 to Dr. Leder.

I further understand and agree that, if any monies for services rendered by Dr. Robin Leder are paid directly by my insurance company to me and/or a member of my family, whether inadvertently, in error, or otherwise, they 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 do so signify by the signing of my name below on this date in front of a witness.

_____
_____
Patient Name (Print) Witness Name (Print)

_____
_____
Patient Signature Witness Signature

_____ Date:
_____
Guardian Name (Print/If Patient is a Minor)

_____
Guardian Signature (If Patient is a Minor)

Date: _____