DAVID D. VAN SLOOTEN, M.D.
LORRAINE S. LIRA, M.D.
PATRICIA G. KLEIN, M.D.
680 Kinderkamack Road, Suite 302
Oradell, NJ 07649

Signature on File

MEDICARE PATIENTS

_____
Name of Patient

I request that payment of authorized Medicare benefits be made on my behalf to David D. Van Slooten, MD, PA for any services furnished me by physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services.

_____ _____
Patient Signature ***Date***

NON MEDICARE PATEINTS

_____
Name of Patient

I irrevocably assign to David D. Van Slooten, MD, PA. All my rights and benefit under any insurance contracts for payment for services rendered to me by David D. Van Slooten, MD, Lorraine S. Lira, MD and Patricia G. Klein, MD irrevocably authorize all information regarding my benefits under any insurance policy relating to any claims by David D. Van Slooten, MD, Lorraine S. Lira, MD and Patricia G. Klein, MD to be released to them. I irrevocably authorize David D. Van Slooten, MD, Lorraine S. Lira, MD and Patricia G. Klein, MD to file insurance claims on by behalf for services rendered to me. I irrevocably direct that all such payments go directly to David D. Van Slooten, MD, PA. I irrevocably authorize David D. Van Slooten, MD, Lorraine S. Lira, MD and Patricia G. Klein, MD to act in my behalf and report any suspected violations of proper claims practices to the proper regulatory authorities.

This assignment of benefits has been explained to my full satisfaction, and I understand its nature and effect.

_____ _____
Patient Signature ***Date***

David D. Van Slooten, M.D., P.A.
Lorraine S. Lira, M.D.
Patricia G. Klein, M.D.
680 Kinderkamack Road, Suite302
Oradell, NJ 07649
(201) 261-6222

Privacy Practices Acknowledgement
and
Patient Consent Form

By signing this form, you are granting consent to David D. Van Slooten, M.D., P.A. to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. By signing this form I acknowledge I have received the Notice of Privacy Practices and I have been provided an opportunity to review it. Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by asking any of our office staff or you may write to our Practice at 680 Kinderkamack Road, Suite 302, Oradell, NJ 07649.

You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance of your consent.

I authorize David D. Van Slooten, M.D., P.A. to discuss my care and/or test results with the following family members, significant others and/or friends.

1. _____ 2. _____

3. _____ 4. _____

NAME OF ASSIGNED HEALTHCARE PROXY_____

PATIENT'S NAME (PRINT) _____

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE_____

RELATIONSHIP TO PATIENT _____

DATE _____