# Elena Sanders, MD, P.C.

**400 Seaview Ave**

**Staten Island, NY 10305**

**Phone 718-980-0055 Fax 718-980-0058**


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Name: _____ Date of Birth_____

## Privacy Practices Acknowledgment

I have received the Notice of Privacy Practices

Signature _____ Date_____

## Assignment of Benefits

I hereby consent to examination and treatment by Dr. Elena Sanders and her staff.

I request that payment of authorized medical insurance, worker's compensation, no-fault, or Medicare/Medicaid benefits be made on my behalf to Elena Sanders, MD, P.C. for services furnished to me by Dr. Elena Sanders.

I understand that any unpaid deductible and/or co-pay is due on the day of the visit or procedure. I understand that charges not payable by insurance are my responsibility and all payments are due in full within 90 days from the date of service.

Signature _____ Date_____