SEAN L. KAUFMAN, D.P.M., F.A.C.F.A.S.
MICHAEL RALLATOS, D.P.M., A.A.C.F.A.S.
KENNETH DONOVAN, D.P.M., A.A.C.F.A.S.

528 Boulevard
Kenilworth, NJ 07033
Telephone (908) 276 – 6624
Fax (908) 709 – 0163

834 Avenue C
Bayonne, NJ 07002
Telephone (201) 436-4287
Fax (201) 436-5794

Part One:

Acknowledgement Of Receipt of Notice Of Privacy Practices

I acknowledge that I was provided with a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

____

Print - Patient Name
OR Print - Parent/Authorized Representative Name (if applicable)

____ ____________________

Signature of Patient Date
OR Parent/Authorized Representative

Part Two:

Authorization to Pay Benefits To Physician

I hereby authorize and request payment directly to Dr. Sean Kaufman and/or Dr. Michael Rallatos for any surgical and/or medical benefits due under the terms of this insurance policy for services rendered.

____________________________________ ____________________

Signature of Patient Date
OR Parent/Authorized Representative