NEW YORK LASER VISION

Medical and Surgical Eye Care

Julia Giyaur, MD
Fellow of American Board of Ophthalmology
Member of American Academy of Ophthalmology and
American Society of Cataract and Refractive Surgery
Jinyoung Choe, OD
Member of American Optometric Association and NYSOA
Biana Gekht, OD
Member of American Optometric Association and NYSOA

We are pleased to welcome you to our practice. *Добро пожаловать! Пожалуйста, заполните эту анкету полностью. Обращайтесь к нам с любыми вопросами. Мы будем рады вам помочь.*

c

Patient Information

Patient Name LAST / *ФАМИЛИЯ*_____FIRST / *ИМЯ*_____

Address / *Адрес*_____

City_____State_____Zip Code_____

Social Security Number __ __ __ - __ __ - __ __ __ __ ☐Single ☐Married ☐Divorced☐ Widowed

Date of Birth / *День Рождения* _____/_____/_____ Gender / *Пол* ☐M ☐F

Home Phone Number / *Домашний Номер тел*. (_____)_____
Cell /*Мобильный* (_____)_____ *E-mail:_____

Emergency contact: Name_____ Relationship _____

Phone Number _____

Parent/Guardian Name (if patient is a minor or less than 18 years old)_____

Job Information

Occupation / *Работа, должность* _____
Employer / *Компания, работодатель*_____Phone / *Телефон* _____
Address / *Адрес*_____

*** How did you hear about us? /*Как вы о нас узнали*?**

*** Primary Care Doctor/Internist/**Терапевт

*** Pharmacy** /Аптека

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Cancellation Policy

Please be advised of our cancellation policy. We understand that there may be circumstances that require immediate attention. Please be aware that if you do not cancel your appointment within 24 hours or fail to show up to your scheduled appointment, a 25$ no show fee will apply.

Thank you

_____
*__Patient Signature__

medical claims to my insurance company or Medicare on my behalf. I hereby acknowledge financial responsibility for costs of services rendered for myself or for the person on whose account I am acting as guarantor. I authorize/assign any insurance or Medicare benefits to be paid directly to A& D Medical, PC / Yuliya Giyaur, MD, or its assignees. I understand that I am responsible for any non-covered services, supplies, co-payments, and deductibles. I am responsible for knowing how my plan works. I request medical services at this office. This acceptance and assignment will be in force for all future services rendered by practitioners from this office.

_____ _____

*Signature of Patient or Patient's Guardian / Representative Date

_____

*Printed Name of Person signing above

Acknowledgement of Notice of Privacy Practices

I hereby give my consent for Yuliya Giyaur, MD / A & D Medical, PC to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPO).
I have the right to review the Notice of Privacy Practices prior to signing this consent. Yuliya Giyaur, MD / A & D Medical, PC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to A & D Medical, PC 97-13 64th Road, Rego Park, NY 11374.

With this consent Yuliya Giyaur, MD / A & D Medical, PC or any representatives may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that Yuliya Giyaur, MD / A & D Medical, PC restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Yuliya Giyaur, MD / A & D Medical, PC's use and disclosure of my protected health information to carry out treatment, payment, and healthcare operations.

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I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or if I revoke it at a later time, Yuliya Giyaur, MD / A & D Medical, PC may decline to provide treatment to me.

_____ _____

*Signature of Patient or Patient's Guardian / Representative Date

_____

*Printed Name of Person signing above

STATEMENT OF PATIENT FINANCIAL RESPONSIBILITY

***Patient's Name**_____ **Date** _____ **File/Accnt #** _____

New York Laser Vision appreciates the confidence you have shown in choosing our ophthalmology practice toprovide for your vision care needs. The service(s) you have elected to participate in implies afinancial responsibility on your part. It is your responsibility and absolute obligation to ensurepayment in full for our fees. As a courtesy, we will make every effort to obtain accurate information from your insurance carrier, if any, and verify your insurance coverage and your insurance carrier on your behalf. However, please note that verification of benefits and acceptance of assignment of your insurance benefits is not a guarantee that your insurance carrier will pay our claims in full.

YOU ARE ULTIMATELY RESPONSIBLE FOR THE PAYMENT IN FULL OF THE FEES FOR SERVICES RENDERED TO YOU BY NEW YORK LASER VISION!

INSURANCE IS ACCEPTED UNDER THE FOLLOWING CONDITIONS ONLY: You are responsible for payment of any co-payment at the time of service and promptly upon receipt of a bill for any deductible/coinsurance as identified by your insurance carrier. Many insurance companies have additional stipulations that may affect your coverage. **You are responsible for any amount not covered by your insurer.** You agree to pay all deductibles, coninsurance, copayments, fees (in full) for non-covered services and other fees deemed "patient responsibility" by your insurance carrier upon adjudication of the claim submitted on your behalf for the services rendered to you by New York Laser Vision. You are fully and solely responsible for obtaining any necessary referral(s) from another physician(s) prior to your appointment date and providing such referral(s) to our office at the time of your appointment. Please note that any claim payment(s) denied due to lack of a referral become the patient's responsibility.

I have read the above policy regarding my full financial responsibility to New York Laser Vision for services provided to me (or the above named patient). I certify that the information provided is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to New York Laser Visions. I agree to pay New York Laser Vision the full and entire amount of all bills incurred by me (or above named patient); or if applicable, any amount due after payment has been made by my insurance carrier

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CO-PAYMENT POLICY: Some health insurance carriers require the patient to pay a co-pay for healthcare services rendered. In accordance with the applicable laws and regulations, it is the policy of our practice that **co-payments are paid in full at the time of the visit.** Your full cooperation is appreciated.

Consent for Treatment & Authorization to Release Information

I hereby authorize New York Laser Vision through its appropriate personnel to furnish medical care and treatment to me (or the above named patient) considered necessary and proper in diagnosing or treating my (his/her) condition

I further authorize New York Laser Vision to release to appropriate agencies any information acquired in the course of my (or the above named patient's) examination and treatment necessary to secure payment for services provided.

* **Patient Signature** _____ **Date** _____

Guarantor Signature _____ **Relationship to Patient** _____**Date** _____

Authorization for Medical and/or Office Surgical Procedures

I understand that proper diagnosis and treatment may require the physician to perform minor surgical and medical procedures and treatments and to administer local anesthetics, medicines, ultrasound, and other tests and medical procedures. I, therefore, authorize such operations, diagnostic procedures, treatments and administrations were performed by physician, nurses, and technicians.

I understand that most laboratory specimens collected at this facility are sent to an outside laboratory, which bill the patient unless covered under a health insurance policy.

I understand that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been or will be made to me as in the results of treatments or examinations.

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I authorize the release of my medical records, including diagnosis, treatment, procedures, and recommendations to my family medical doctor or referring physician, and if necessary to my insurance carrier.

I am fully aware of the contents of this form that I am signing, and understand that I may withdraw consent by crossing out and initialing any section above.

*

Patient signature or Responsible Party Date

Witness Date