Michael Ahdoot, MD

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www.TheNewYorkEyeDoctor.com

PATIENT INFORMATION

Last Name: _____ First Name: _____ Date of Birth: _____ Age: _____

Address: _____ Apt: _____ City: _____ State: _____ Zip Code: _____

Tel: Home: _____ Cell: _____ Other: _____ Email: _____

Social Security #: _____ **Circle**: Male / Female Single / Married / Other Parent/ Guardian (if minor) Name: _____

Referred By: _____ Primary Care Physician/Pediatrician: _____ Tel: _____

Pharmacy Name & Location: _____

INSURANCE INFORMATION

Primary Insurance: _____ Secondary Insurance: _____

Policy Holder: _____ Relation to Patient: _____ Policy Holder SS#: _____ Policy Holder Date of Birth: _____

PLEASE READ AND SIGN

Patient and/or guarantor are responsible for charges incurred. It is a courtesy for Michael Ahdoot MD PC to file your insurance, however you are responsible for your copay and/or percentage, which the insurance company is not liable for on the day of your visit. In the event your insurance company has not paid within 60 days you are responsible for the balance due. It is also the patient's responsibility to obtain referrals from your primary care physician when required. If the referral is not obtained before the visit, the patient is liable for payment in full on the date of service. If we are unable to obtain payment within a reasonable amount of time from the patient and/or guarantor we reserve the right to place your account with a collection agency, which will leave you liable for additional expenses incurred if applicable. By signing below, I agree that I have fully read and understand the above statement of payment policy. I hereby request any benefits on my behalf, to be paid to Michael Ahdoot MD PC dba Progressive Ophthalmology. I also authorize the release of any information acquired in the course of my treatment to my insurance company as needed to issue benefits. I authorize Dr. Michael Ahdoot and his staff to administer such treatment, as they may deem advisable, for my diagnosis and treatment. I certify that I have been made aware of the role and services offered by Dr. Michael Ahdoot and his staff I consent to care by such providers. I understand that these services are voluntary and that I have the right to refuse these services.

Signature: X_____ Print Name: _____ Relation to Patient: _____ Date: _____

I understand that, under the Health Insurance Portability & Accountability Act (HIPPA) of 1996, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly; Obtain payment from third party payers; Conduct normal healthcare operations such as quality assessments and physician certifications. I have been informed by Michael Ahdoot MD PC of its Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that Michael Ahdoot MD PC has the right to change its Notice of Privacy Practices from time to time and that I may contact Michael Ahdoot MD PC at any time to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that Michael Ahdoot MD PC restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand Michael Ahdoot MD PC is not required to agree to my requested restrictions, but if it does agree then it is bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that Michael Ahdoot MD PC has taken action relying on this consent.

Signature: X_____ Print Name: _____ Relation to Patient: _____ Date: _____