eye center of NEW YORK

TAL RAVIV, MD, FACS
PAUL LEE, MD, FACS
MELISSA SHERMAN, OD

Patient Name: _____ Date of Birth: _____

AUTHORIZATION AND CONSENT

I hereby authorize that payment from my medical insurance program or my Medicare benefits be made to the above named physician on any unpaid bills for services provided on or after today. I also authorize any holder of medical or other information about me to release to their health care financing administration, its intermediaries, insurance companies, or their agents any information needed to determine benefits payable for services. I permit a copy of this authorization to be used in place of the original. I understand that I am financially responsible for any balance not covered by my insurance carrier.

NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT

I have received (or been able to access at the office) this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosure of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practice's current Notice of Privacy Practices on Request.

_____ _____

Signature of patient or authorized representative Today's date