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.

APPOINTMENT CANCELLATION POLICY

Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care. Missed appointments or appointments that are not cancelled in an appropriate amount of time are a lost opportunity for us to help another patient. We do understand there may be circumstances when you may be unable to keep your appointment. We ask that you give us a 24-hour notice of cancellation or reschedule. It is our policy to charge **$50** for all missed appointments or appointments *(new or established patients)* that are not cancelled and/or rescheduled 24 hours prior the appointment time.

_____ _____

Signature of patient or authorized representative Today's date