NEW YORK EYE AND FACE
OCULOPLASTIC SURGERY

Name _____ Date of Birth _____

Address _____ □ Male □ Female □ Other _____

Home Phone _____ Mobile Phone Number _____

Social Security Number _____ Email _____

Preferred Method of Contact: □ Home Phone □ Mobile Phone □ Work Phone □ Email

Consent to Text Messages: □ Yes □ No

Emergency Contact Name _____ Phone Number _____ Relationship to Patient _____

Primary Care Physician Name and Address _____

Referring Physician Name and Address _____

Preferred Pharmacy Name and Address _____

How did you hear about us? □ Online Search □ Instagram □ Print Ad □ Insurance Website □ Referred by Physician

Other:_____

What medications do you take?_____

_____

Medication Allergies: □ None or _____

Smoking Status: □ Current Smoker □ Former Smoker □ Never Smoker

Prior Surgeries, Eye Surgeries, Implants: □ None or _____

Past Medical History (circle all that apply): □ NONE of the below apply

Anesthesia Problems	Depression	Currently Pregnant or Nursing
Anxiety Disorder	Diabetes	Seizure Disorder
Bleeding Disorders	Heart Disease: _____	Sleep Apnea
Cancer History	High Cholesterol	Skin Cancer: _____
Defibrillator or Pacemaker	Hypertension	Stroke History

OTHER:

_____

Patient Signature_____ **Date** _____

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Frequently Asked Questions Regarding the Credit Card on File Agreement

Do I have to leave my credit card information to be a patient at this practice?
Yes. This is our policy and it is a growing trend in the healthcare industry. Insurance reimbursements are declining and there has been a large increase in patient deductibles. The amount of time and effort to collect payments that will be saved will allow our office to focus more on patient care. We have decided to focus on becoming more efficient in our billing and collections processes instead.

How much and when will money be taken from my account?
The insurance companies on average take approximately 2-3 weeks to process submitted claims. Whatever the allowed amount is, your copay, coinsurance, and deductible are taken into consideration. It simply depends on your individual policy what you may owe. Once the insurance explanation of benefits is received and posted to your account, you will be sent a statement showing your portion. You will have 30 days to send an alternative form of payment if you prefer. If no alternative payment is received, your patient's financial responsibility will be processed.

How do you safeguard the credit information you keep on file?
We use the same methods to guard your credit card information as we do for your medical information. The card information is securely protected by the credit card processing component of our PCI and HIPAA compliant practice management system. This system stores the card information for future transactions using the same sort of technology that any online retailer would. We can't see the card number – only the last four numbers, giving us no way to use the card outside of the billing system. There is no way to export the card information out of our system. The only way to use it is to process a payment in our practice management system.

What are the benefits?
It saves you time and eliminates the need to write checks, buy stamps or worry about delays in the mail. It also drives our administrative costs down because our staff sends out fewer statements and spends less time taking credit card information over the phone or entering it from the billing slips sent in the mail, which are less secure methods than us storing the information. The extra time the staff has can now be spent on directly helping the patients, either over the phone, with insurance claims or in person.

What if there is a payment discrepancy or I have other payment questions?
Please contact our office directly to settle payment discrepancies or for other payment questions. This policy in no way compromises your ability to dispute a charge or questions your insurance company's explanation of benefits. Will I still receive a receipt/invoice bill by mail? Yes. You will receive a paid receipt/invoice for each transaction by mail or email based on your preference.

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Credit Card on File Agreement

Much like many other businesses such as hotels, car rental agencies, medical practices, attorneys, etc., New York Eye and Face Oculoplastic Surgery, PLLC has a policy where a credit card on file is required, which may be used later to pay any balance that may be due on your account.

In Network Patients
Your credit card information will be obtained and kept securely until your insurance(s) have paid their portion and notifies us of the balance due, if any. Balances owed will be applied to the card on file. These transferred amounts are outlined in the Explanation of Benefits (EOB) that is mailed to you by your insurance company. Your ability to dispute a charge or question your insurance company's determination of payment will remain unchanged. If you have any questions about our policy, please read the FAQ on the next page and do not hesitate to ask.

Out of Network Patients
All balances are due at the time of service. The card on file will be charged accordingly the day of your visit/procedure.

New Patient Appointment Deposit
Our office requires a deposit for holding new self-pay patient appointments. This deposit will be applied towards your initial visit. If you are not sure that you will be able to keep your new patient appointment, please do NOT schedule at this time. The deposit is: $250.00 for cosmetic evaluation, which is credited towards any completed cosmetic service & $350.00 for any self-pay medical evaluation. If you need to cancel/reschedule your appointment you need to do so within 48 hours prior to your appointment. Failure to do so will result in a $75.00 late cancellation or no-show charge.

By signing below, I authorize New York Eye and Face Oculoplastic Surgery, PLLC to keep my signature and my credit card information securely on-file in my account. I authorize New York Eye and Face Oculoplastic Surgery, PLLC to charge my credit card for any outstanding balances when due. If the credit card that I give today changes, expires, or is denied for any reason, I agree to immediately give New York Eye and Face Oculoplastic Surgery, PLLC a new, valid credit card which I will allow them to charge over the telephone. Even though New York Eye and Face Oculoplastic Surgery, PLLC is not processing the new card in person, I agree that the new card may be used with the same authorization as the original card I presented. I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form. Should you wish to revoke this authorization at any time, please send written notice to the office.

Card Holder's Signature: _____ Date: _____

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Office Policies and Patient Financial Agreement Acknowledgement

Insurance. At your first visit, we ask that you bring your current insurance card. The practice will submit claims to your insurance company when there is an established contract between the insurance carrier and New York Eye and Face Oculoplastic Surgery PLLC. The practice will attempt to verify eligibility and coverage benefits prior to procedures and/or office visits. While the office will address insurance at each visit, if there are any changes in coverage, it is the patient's responsibility to inform the office. It is your responsibility to be aware of and understand your health plan and policy terms. If your insurance company requires prior authorization, it is your responsibility to make sure one is in place prior to your visit. **If no authorization is in place, you accept full financial responsibility.**

Non-Covered Services. Not all services are a covered benefit in all policies. If your insurance claim is denied for any reason, the practice will give a best effort to appeal denials when appropriate. **Any rendered services not covered and/or denied claims by insurance will become the patient's responsibility**.

Payment. Payment is expected **at the time of service.** This includes insurance deductibles, copayments, and coinsurances. Payment can be made with cash, personal check, or credit card. If you are unable to make your copayment at your visit, your visit may need to be rescheduled. The practice policy is to keep a credit card on file. This is similar to how your credit card may be on-file with online retailers. This allows convenience for patients with making payments. You will be notified 5 days before payment. The practice does not store the card information, it is stored within the secure credit card processing system within your medical record. Payment is expected within 30 days of service. After that time, your account may be sent to collections, in which case you will be responsible for the additional fees for collections. NSF or rejected checks may incur a $25 fee.

Out of Network, Cosmetic, Self-Pay Patients. Payment is expected at the time of service. Full payment for surgery is due 2 weeks prior to your surgery date. Surgery cancellation within 48 hours of surgery will result in a charge equal to **25% of the surgical fee**, and the rest refunded. While perfection is not the goal of surgery, in the event of a request for a surgical revision, the patient will be charged for the facility and anesthesia costs for performing the revision.

Cancellation and No-Show Policy. Our office will follow up on missed and/or canceled appointments by phone call and/or a letter. This is not meant to verify that you are receiving the appropriate care for your condition. We understand that there are situations when you must cancel your appointment. We request you provide the office with 48-hour notice in the event of a cancellation. Patients who do not show up with more than 48-hour notice are considered a "no-show" and may be subject to a **$75 cancellation fee**. **Patients with two (2) or more "no shows" in a 12- month period may be dismissed from the practice**.

Professional Behavior Agreement. As a patient of this practice, I have the right to be treated with professionalism and respect by physicians and staff members. In return, I have a responsibility to treat staff members and physicians with professionalism and respect. I understand that non-compliance with this professional behavior agreement may be grounds for dismissal from the practice.

Medical Records/Employer Paperwork. Patients have the right to their medical records. If requested, the patient must complete a HIPAA Medical Release Form. Records released through the patient portal will not be charged. A fee may be applied for printed copies of patient medical records. Fees may also apply for FMLA or other paperwork requested by the patient's employer.

Medicare Patients. Medicare insurance forms will be submitted by the practice. Medicare allows providers to obtain a one-time signature that can be used for Medicare benefits. By signing this document, you agree that in lieu of a signature, "Signature on File" will appear on all Medicare forms submitted by this practice on your behalf.

Assignment of Benefits. I hereby assign all medical and surgical benefits to which I am entitled. I hereby authorize and direct my medical insurance to issue payment on my behalf to New York Eye and Face Oculoplastic Surgery PLLC. I authorize the practice to release information, including medical information, to insurance carriers necessary for payment. I understand that I am financially responsible for all charges, whether or not they are paid for by my medical insurance. I permit a copy of this authorization to be used in place of the original.

By signing below, I certify I have read, understand and accept the above conditions and terms.
I understand and agree this document will remain in effect for all future outpatient or physician office visits to New York Eye and Face Oculoplastic Surgery PLLC, unless specifically rescinded in writing by me, which I may do at any time.

Name (Print)_____ Signature_____ Date_____

HIPAA Acknowledgment and Consent Form

Purpose of Consent: I understand that I have certain rights to privacy regarding my protected health information, under the Health Insurance Portability and Accountability Act of 1966 (HIPAA). By signing this form, you consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.
Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. The notice describes how we may use and disclose your protected health information and other important matters about your protected health information. We encourage you to read it carefully and completely before signing this consent. You may obtain a copy of our Notice of Privacy Practices at any time by contacting: 914-339-6050, 244 Westchester Avenue Suite 111 West Harrison NY 10604
Right to Revoke: You have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the above contact. Revocation of this consent will not affect any action we took in reliance of this consent prior to receiving your revocation.
Signature: I have had the opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations

Name (Print)_____ Signature_____Date_____

Photo Consent and Release Form

Our practice often utilizes before and after photos or videos taken of medical and/or cosmetic procedures and treatments for internal and commercial uses. Please be aware that patients will not be compensated for the use of any image(s) for which they have given permission to New York Eye and Face Oculoplastic Surgery PLLC to use for marketing purposes. Patient's identities may be concealed by obstructing areas of the face. Photos or videos will not be identified by name.
You agree to:

- Allow images to be used by health professionals for education and training
- Images to be used in print, email or web based advertisements on the practice website, and/or social media accounts to show before and after results.
- Waive any claim, cause of actions, damages or loss (including attorney's fees) that you may have against New York Eye and Face Oculoplastic Surgery PLLC or its officers, employees, agents, and affiliates arising out of its use of the photos and/or videos to promote its advertising efforts.
- Waive any right to inspect the photographs, videos or any advertising or promotional copy that may be used in connection therewith.
- Assign to New York Eye and Face Oculoplastic Surgery PLLC any and all rights, title and interest in and to any photographs or videos taken of you for the purposes above, including but not limited to the copyright and in any renewals and extensions thereof that may be secured under the law now or in the future in the United States or any other country or countries.
- Allow the rights granted herein to be exercised by New York Eye and Face Oculoplastic Surgery PLLC at any time hereafter for perpetuity, without limitation.

You have the option to decline this request and are not obligated in any way to provide permission to use these photos or videos, except for the sole purpose of documentation in your own medical record.
This consent may be revoked at any time with a written consent from the patient or patient representative.
I certify that I have read the above consent and release form and fully understand its terms.

Name (Print)_____Signature_____Date_____