NEW YORK LASER VISION

Medical and Surgical Eye Care
www.nylaservision.com
info@nylaservision.com

2464 Coney Island Ave, 3rd Fl, Brooklyn, NY
Ph: (718) 676-6464
Fax: (718) 676-6467

133 E 58th St, Suite 1102, New York, NY
Ph: (212) 316-1200
Fax: (929) 493-3040

Julia Giyaur, MD
Fellow of American Board of Ophthalmology
Member of American Academy of Ophthalmology and American Society of Cataract and Refractive Surgery
Milana Sapozhnikov, MD
Fellow of American Board of Ophthalmology
Anastasiya Zagurskaya, OD
Member of American Optometric Association and NYSOA
Sarah Pinkhasov, OD
Member of American Optometric Association and NYSOA
Rachel Mindin, OD
Member of American Optometric Association and NYSOA
Selena Huang, OD
Member of American Optometric Association and NYSOA

I authorize the release of any information acquired in the course of treatment necessary to complete and file 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.

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 92464 Coney Island Ave Brooklyn NY 11223.

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.

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.

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.

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.

By entering my first and last name, I acknowledge my agreement with all the information provided below. I am fully aware of the contents of this form and understand that I may withdraw my consent by crossing out and initialing any section above.