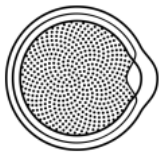

New York Ophthalmology +

Name:
DOB:
Date:

Effective Date: June 1, 2014

Notice of Privacy Practices Privacy Committee (888-212-3937)

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy of privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. lf you have any questions about this Notice, please call at 1-888-212-3937. the contact officer of the Privacy Committee listed above.

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that l received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Signed _____Date_____ Printed Name _____

If not signed by the patient, please indicate the relationship:

Parent or guardian of minor patient

Guardian or conservator of an incompetent patient

Name and Address of Patient:

_____

o: 888.212.3937
f: 718.585.5502
e: hello@nyoph.com
w: nyoph.com
a: 329 E 149th St, 2nd Fl, Bronx, NY 10451
74-09 37th Avenue, Suite #303, Jackson Heights, NY 11372
147-32 Jamaica Avenue, Lower Level, Jamaica, NY 11435

New York Ophthalmology +

NAME:
DOB:
Date:

Insurance Billing

Information which the insurance company may request concerning my present illness or injury.

I hereby assign to the doctor whose name appears above all the money to which I am entitled for medical and/or surgical expense relative to the service reported above. I understand that I am financially responsible to said doctor(s) for charges not covered by this assignment.

SIGNATURE_____ PATIENT_____ DATE_____

NO INSURANCE: Payment is due at the time of service; however, we do allow financial arrangements. Non-paid accounts are referred to a collection agency ninety (90) days after the first charge.

INSURANCE: Co-payments, deductibles, or non-covered charges are due at the time of service. Non-paid accounts are referred to a collection agency one hundred and twenty (120) days after the first charge. We may bill your insurance for you; however, this does not release your responsibility for payment on any charges not paid by your insurance.

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New York Ophthalmology +

Name:
DOB:
Chart:
Date:

Consent for E-mail Communication

Email: _____@_____

I hereby consent to E-mail communication between New York Ophthalmology and myself, for the explicit purpose of receiving login instructions and information for the online patient portal.

The online patient portal is a secure website through which New York Ophthalmology can communicate with patients who have created accounts. CMS (Center for Medicare & Medicaid Services) has mandated that healthcare professionals providing services to Medicare and Medicaid patients must provide patients with the ability to view online patient health information.

I also consent to informational emails and non-patient specific reminders. E-mail will never be used for communications regarding patient identifiable medical or financial issues. I understand that in an urgent or emergent situation should call my provider or go to the Emergency Room and not rely on E-mail or the patient portal. New York Ophthalmology, will not sell or distribute E-mails to third parties for commercial or marketing purposes.

Consent Decline

Signature_____ Date_____

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New York Ophthalmology +

Consent For Use of Electronic Prescription Information

I agree that New York Eye Ophthalmology may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payers for medical care and treatment purposes.

Consent _____ Decline _____

Signature _____

Date: _____

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