NY Vision Group
www.nyvisiongroup.com

119-15 Atlantic Ave
Richmond Hill, NY 11418
Tel: (718) 805-0700
Fax: (718) 805-2269

37 Murray Street
New York, NY 10007
Tel: (212) 243-2300
Fax: (646) 370-1418

279 Wyckoff Avenue
Brooklyn, NY 11237
Tel: (718) 381-1632
Fax: (718) 381-3674

(Please Print)

Today's Date ____/____/____ Primary Care Physician_____

PATIENT INFORMATION

Patient's Last Name	First	Middle	❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.	Marital Status (Circle One) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former Name)	Birth Date / /	Age	Sex ❑ M ❑ F

Street Address	APT.	City	State	ZIP Code	Social Security	Home Phone No. ( )

Email Address

Occupation	Employer	Employer Phone No. ( )

Chose Office Because/Referred to Office by (Please check one box) ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital
❑ Family ❑ Friend ❑ Close to Home/Work ❑ Yellow Pages ❑ Other _____

Name & Telephone number of Medical Doctor TELEPHONE: ( )

Pharmacy Name and Telephone TELEPHONE: ( )

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD & ID TO THE RECEPTIONIST)

Person Responsible for Bill	Birth Date / /	Address (if different)	Home Phone No.
Is this person a patient here?	❑ Yes ❑ No		( )

Occupation	Employer	Employer Address	Employer Phone No. ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance

Subscriber's Name	Subscriber's S.S. #	Birth Date / /	Group #	Policy #	Co-Payment $

Patient's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other _____

Name of Secondary Insurance (if applicable)	Subscriber's Name	Group #	Policy #

Patient's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other _____

IN CASE OF EMERGENCY

Emergency Contact Name	Relationship to Patient	Home Phone No. ( )	Work Phone No. ( )

I authorize the release of any medical information necessary to process this claim and request payment of benefits to Harry Koster, M.D. PC (the "PC"). I understand that I am financially responsible for all fees and will be billed for any balance, deductible and co-payment which my insurance does not cover. **I further authorize the use of the information I have provided herein by the PC or its authorized third party providers to contact me regarding my appointments and/or matters related to the PC.**

If I am a member of a managed care program, I am aware that it is my responsibility to provide the PC with an appropriate referral form. If the PC unable to collect from my insurance company because of my failure to provide it with an appropriate referral in a timely manner, I agree that I will be responsible to pay for these services personally.

I have received a copy of the Notice of Privacy Practices and I have been provided an opportunity to review it.

X _____
PATIENT/GUARDIAN SIGNATURE DATE

PATIENT CELL PHONE NUMBER:_____

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PATIENT AGREEMENT (OFFICE POLICIES)

1. Please notify the front desk on any changes in the following:

a. Health Condition	d. Phone number
b. Insurance	e. Work number
c. Address	f. Cell number

2. In order to expedite your time in the office, please correct your personal information, hand in your referral (if needed) and pay all payments prior to being seen.

3. ALL co-pays/deductibles and co-insurance payments must be made at time of visit.

4. Any and all diagnostic testing should **NEVER** be missed. Test results are vital to your doctor's ability to determine the appropriate treatment plan for you.

5. We will utilize your insurance based upon your policy provisions. However, the ultimate responsibility rests with the patient.

6. Please be aware that insurance companies authorize referral visits two ways:
   I. They issue a number of visits.
   II. They issue a time frame. If visits are not utilized within the time frame you are given, the visits will expire. You are responsible to know how many visits you have and when the time frame is up.

7. A diagnostic co pay is due for GHI & Empire plan based on your policy. Will be collected a time of check-out.

8. There are some insurance companies that **do not cover** refractions. If you are here for an Eyeglass prescription and your insurance does not cover the refraction cost, you are responsible to pay the refraction fee at the time of the visit.

9. Please inform the front desk if you are here for contact lens fitting or contact lens verification visit. Fees for this service are listed separately. In addition, Contact lens must be paid in full prior to ordering. If you are here for a contact lens fitting/verification, please ask for a copy of the FDA guidelines and explanation of exam/fees.

10. Food and drink are not permitted in the office. Please help to keep our office clean.

11. I am aware that the **Patient Privacy Notice** has been updated and is available for review.

_____	_____	_____
Print Patient's Name	Patient's Signature	Date

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Protected Health Information Release Form

Patient Name: _____

Date of Birth: _____

Date: _____

Please circle all that apply:

I hereby authorize the following individuals(s) *full / partial* disclosure of my medical records including: *diagnosis, treatments, billing issues, appointment information and prescriptions,* in accordance with HIPAA regulations.

Concerning matters of my health, I give permission to speak with:
***It is my responsibility to notify the office, in writing if I no longer wish the individuals listed to have access to my records, or any other change to availability of my information.**

Name of person(s) _____ relationship to patient _____

Name of person(s) _____ relationship to patient _____

Name of person(s) _____ relationship to patient _____

Name of person(s) _____ relationship to patient _____

Signature of patient: _____

Witness: _____