

Date:

Dear

Dr. Maisel would like to take this opportunity to welcome you to the Retina Group of New York. We have enclosed a registration form for you to complete at home. It will save time if you bring these completed forms when you come to our

_____ office for your visit on _____.

You can expect to be in the office approximately 2 hours, depending on your eye problem, and the type of testing and treatment required. There is Handicap parking on the South side of the Hicksville building or the Northeast parking lot by the ramp in Islandia for your convenience.

You will need to come with a driver, since your eyes will be dilated for several hours. Make sure you fill out both sides of the application, including the names and addresses of your primary care and referring doctors, and the amounts and types of medications you take. Also, please remember to bring your glasses.

We participate in a number of insurance plans, including Medicare, but you will be responsible for any deductible or co-payment. We would be happy to assist you with any paperwork, if necessary.

IF YOUR INSURANCE COMPANY REQUIRES PRIOR APPROVAL OR REFERRAL AUTHORIZATION, PLEASE BE SURE THAT WE RECEIVE IT BEFORE YOUR VISIT.

If you have any questions prior to your appointment, please do not hesitate to call us.

Sincerely,

James M. Maisel, M.D.

RETINA GROUP OF NEW YORK

Responsible Party Information (Insurance Holder)

Last Name: _____ MI: _____ First Name: _____
Street Address: _____ City: _____ State: _____ Zip: _____
Home Phone #: _____ Cell #: _____ Work #: _____
Date of Birth: _____ Social Security #: _____ Sex: M or F
Ethnicity: _____ Primary Language: _____
Employer: _____ Employer Address: _____
Your/Caregiver E-Mail Address: _____ Emergency Contact #: _____
Is the Patient residing in a Nursing Home/ Assisted Living/ Rehab? Y or N If Yes, Name and Address: _____

Dependent Information (If Insurance Holder is NOT the Patient)

Last Name: _____ MI: _____ First Name: _____
Date of Birth: _____ Social Security #: _____ Sex: M or F
Home Phone #: _____ Cell #: _____ Work #: _____

Insurance Information

Primary Insurance Name: _____ Member I.D. #: _____
Secondary Insurance Name: _____ Member I.D. #: _____

PAYMENT OF BENEFITS: I authorize payment of benefits, as determined by the company, directly to James M. Maisel, M.D. Y or N

I understand that unless I have checked "YES" above, benefit payments will be paid to me. I also understand that even if I have checked "YES" above, as the responsible party, I agree that all charges that are not directly paid by my insurance company will be my responsibility.

X _____ Date: _____

MEDICAL RELEASE AUTHORIZATION (Dependent must also sign if not minor)

I authorize any insurance company, organization, employer, hospital, physician, dentist or pharmacist to release any information requested with regard to processing my claim. I certify that the information I furnish is true and correct. I know it is a crime to fill out this form with facts I know are false or to leave out facts I know are important.

X _____ Date: _____

400 South Oyster Bay Road, Suite 305
Hicksville, NY 11801-3516
Tel (516) 939-5100
Fax (516) 939-2510

Vitreoretinal and Laser Surgery
www.rgony.com

1455 Veterans Memorial Highway
Hauppauge, NY 11749
Tel (631) 273-1818
Fax (516) 939-2510



Medical History

*What is your reason for today's visit? _____

*Do you experience any of the following? (Please circle all that apply)

Migraines/Headaches

Distortion

Floaters

Flashing Lights

Tearing

Difficulty Reading

*Name and dosage of current medications (include eye drops & over the counter meds):

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

*Do you have any allergies to foods/medications? (Please list) _____

*Have you undergone any past surgical procedures? (Please list) _____

*Do you have any history of eye problems/undergone any procedures? _____

*Do you smoke? **YES** **NO** *Height: _____ *Weight: _____

*Referring Doctor (Name & City): _____

*Primary Care Physician (Name & City): _____

*Specialty Doctors (Cardiologist, Neurologist, etc.): _____

*Pharmacy (Name & City): _____

SIGNATURE ON FILE

☐ **MEDICARE**

I request that payment of authorized Medicare benefits be made on my behalf to James M. Maisel, M.D. for the services furnished me by James M. Maisel, M.D. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or benefits payable to related service.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the HCFA 1500 form of elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown.

James M. Maisel, M.D. accepts the charge determination of the Medicare carrier as the full charge and the patient is responsible only for deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare Center.

☐ **SECONDARY**

If a Medigap policy or other health insurance is indicated in Item 9 of the HCFA 1500 claim form or elsewhere on other approved claim forms, my signature authorized release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made either to me or on my behalf of James M. Maisel, M.D.

Beneficiary

Medicare Number

Beneficiary Signature

Date

HIPAA Privacy Authorization Form

I authorize the Retina Group of New York to use and disclose the protected health information described below to:

Name, Phone Number: _____

Relationship: _____

(individual(s), Family or Friend(s) seeking any information).

This authorization for release of information covers the period of healthcare from all past, present, and future periods.

I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

This medical information may be used by the person(s) I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

This authorization shall be in force indefinitely unless I indicate an expiration date.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of patient/personal representative

Date

Printed name of patient/personal representative
and his or her relationship to patient

Date