

Patient Registration Form

MITCHEL ASHKANAZY MD

Date	Account ID	Chart ID	Other ID	Internal Use
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Patient Information							
Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Age	Social Security #
Address			Home		How did you hear of us?		
Address 2			Work				
			Cell				
			Email				
City			State		Zip Code		Employer Name & Address
							Occupation
Emergency Contact			Phone		Employer Phone		Phone
							Pharmacy
							Pharmacy Phone

Provider	Family Physician (PCP)	Referring Physician
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HIPAA Approved Contacts							
1. Last Name	First Name	Middle	Gender	Birthdate	Social Security #	Relation	
							Spouse
Address		City	State	Zip Code	Home	Cell	Work
2. Last Name	First Name	Middle	Gender	Birthdate	Social Security #	Relation	
							Child
Address		City	State	Zip Code	Home	Cell	Work

Patient's or Authorized Person's Signature

I the undersigned give my authorization to treat and assign directly to MITCHEL ASHKANAZY MD , all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am ultimately financially responsible for all approved and covered charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand that payment is expected at the time of service.

I acknowledge receipt of the Practice's Notice of Privacy Practices. I authorize the Practice to use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me, and conducting healthcare operations.

Signature	Signature Date	MITCHEL ASHKANAZY MD
X		170 KIINELON RD STE 27, KINNELON, NJ 07405 Phone: 973-838-1211

Please attach all pertinent insurance ID cards for photocopying.

FINANCIAL POLICY

We are committed to providing you with the highest level of service and quality care. If you have medical insurance, we will strive to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our financial policy. Ultimately, however, any and all financial liability rests with the patient.

Our office participates with most major insurance plans. We provide **MEDICAL and SURGICAL** ophthalmologic care to our patients, as opposed to **routine eye exams**. **If you have a managed care plan that requires a referral to see a specialist, you must obtain a referral in order for your visit in our office to be covered under your medical insurance.** If you do not have the valid referral and still wish to be seen, you will be asked to pay for the visit prior to your examination. **A refractive examination is not a covered service by most insurance companies, including Medicare. If a refraction is performed, you will be charged for this service.**

It is the patient's/parent's/guardian's responsibility to:

- Be familiar with the benefits of your plan, including co-pays, co-insurance and deductibles.
- Bring all of your current insurance cards to all visits.
- Provide our office with current information including address, phone numbers and employer.
- In accordance with your insurance contract, you must be prepared to pay your co-pay at each visit. If you do not make your co-payment at the time of the visit, you will be charged an additional **\$15.00 billing fee**. We accept cash, checks and all major credit cards for services.

On occasion the staff may help you in obtaining a referral however we are not responsible for this. If a referral is not obtained and cannot be obtained before the visit you will have the choice of rescheduling the visit or paying the full fee at the time of the visit.

We appreciate prompt payment in full for any outstanding balance. If you are unable to pay a balance in full, please notify our billing department immediately and we will try to work out a payment plan with you. If your account is turned over to our collection agency, you agree to pay any fees imposed by the collection agency in order to collect the overdue amount. Any check payments that do not clear the bank will be subject to a **\$35.00** returned check fee.

Due to the high number of patients requiring comprehensive eye care, waiting times for appointments can be long. Because of this, we have a low tolerance for missed appointments that increase cost and prevent other patients from receiving care in a timely manner.

We will charge a missed appointment fee of **\$25.00** for each appointment that is missed without adequate notice ("no show"). A no show is an appointment that is:

- Missed without notice
- Missed with less than one day's notice

If you must miss a scheduled appointment, please notify our office by phone the day before the appointment. Messages are acceptable and can be left at all times including evenings and weekends.

For all services rendered to minor/dependent patients, we will look to the adult accompanying the patient and/or the parent or guardian with whom the child resides for payment. In cases of separation or divorce, when presenting insurance cards for a dependent enrolled under a subscriber other than you, please be prepared to supply their name, address, phone number, date of birth and social security number. We request that you inform the subscriber that their insurance has been used.

I request that payment of authorized Medicare and/or insurance benefits be made on my behalf to Mitchel Ashkanazy M.D. for any services furnished me by them. I authorize any holder of Medical information about me to release to the Health Care Financing Administration, its agents, or any other insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services. This assignment will remain in effect until revoked by me in writing.

I have read and understand the above financial policy and assignment of benefits.

Signature of patient/guardian/parent

Date

Printed name of patient

Date

OVER

PATIENT NAME: _____

INFORMATION AND CONSENT FOR DILATED EYE EXAMINATION

Dear Valued Patient:

It may be important to your care today to dilate your eyes.

Dilating eye drops are used to enlarge the pupils of the eye to allow the physician to obtain a better view of the inside of your eyes.

Dilation frequently changes vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for us to predict to what degree your vision will be affected. Driving may be difficult immediately after the examination. If you are concerned about these problems, you may wish to make alternative transportation arrangements, although a large number of patients do drive after dilation with the assistance of temporary sunglasses, which we can provide after your dilation.

Adverse reactions, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize the physician and/or such assistants as may be designated by him to administer dilating eye drops. The eye drops are necessary to perform a complete exam of the retina and the back of the eye. This may reveal the presence of a serious systemic condition as well as eye conditions. You further understand and acknowledge that you have been warned of the potential risks that dilating drops may have on your ability to drive and will take appropriate steps to reduce this risk by not driving immediately after your eyes have been dilated or by wearing sunglasses while driving.

I agree to have the dilation examination today.

_____/_____/_____
Patient Signature (or person authorized to sign for the patient) Date

I decline to have the dilation exam today.

_____/_____/_____
Patient Signature Date

INFORMATION AND CONSENT FOR REFRACTION

Thank you for choosing Mitchel Ashkanazy, M.D. for your eye care needs. We MAY need to perform a vision test called a "refraction" (description below) to check your vision today.

A refraction is a diagnostic test used to determine the patient's best ability to see. A refraction is the specific measurements of the refractive state of the eye. A series of lenses are presented to determine which prescription provides the sharpest and clearest vision. This is an essential part of most ophthalmologic evaluations. This test is performed during your annual eye exam or if there has been a decrease in your vision since your last visit. This test is necessary to perform in order for your physician to determine the best visual acuity which is needed to evaluate for possible eye diseases. Occasionally the refraction is used as the basic information for prescribing glasses or other optical devices. However, oftentimes a refraction does not lead to a prescription for glasses.

MOST INSURANCE COMPANIES INCLUDING MEDICARE DO NOT COVER THE REFRACTION TEST.

Our office fee for a refraction is \$49.00 and it is collected in addition to any co-payments, coinsurance or deductible payments at the time of service. I accept full responsibility for the cost of this service.

_____/_____/_____
Patient Signature (or person authorized to sign for the patient) Date

I decline to have the refraction examination today.

_____/_____/_____
Patient Signature Date



HIPAA Notice of Privacy Practices

Mitchel Ashkanazy, M.D.

170 Kinnelon Road. Suite 27

Kinnelon, New Jersey 07405

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

I. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law .

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law, Public Health issues as required by law. Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners. Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent. Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your, best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative notification. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before **April 14, 2003.**

_____do hereby allow you to discuss my Personal Protected Health
information with
Name _____ Telephone Number _____
Address _____

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____ Signature _____ Date _____