DELRAY EYE ASSOCIATES, P.A.

PATIENT INFORMATION

PLEASE PRINT:

1. Patient Name: _____
   Last First Middle
2. Date of Birth: _____ Marital Status: _____
3. Address: _____ Apartment #: _____

   City: _____ State: _____ Zip Code: _____
4. Home Phone Number: _____

   Cell-phone #: _____
5. E-Mail Address: _____
6. Last Four digits of Social Security #: _____
7. Person to contact in case of emergency: _____

   Phone #: _____

Insurance Information: **Are you a member of an HMO? Yes No**
(Health Maintenance Organization)

1. Medicare or Primary Insurance _____
2. Secondary Insurance: _____

PLEASE PRESENT INSURANCE CARDS TO FRONT DESK FOR PHOTOCOPY

LIFETIME AUTHORIZATION

I authorize any holder of medical or other information about me to release the Health Care Financing Administration and its agencies, any information needed to authorize these benefits or the benefits payable for related services. I request that payment of authorized Medicare insurance benefits be made on my behalf to Dr. Rosenfeld, Dr. Kronish, Dr. Schaffer, Dr. Jewelewicz, Dr. Winnick, Dr. Gonzalez, Dr. Glatzer, Dr. Werner, Dr. Saitowitz, and Delray Eye Associates, P.A., for any services furnished me by those physicians. I also agree that any and all balance will be paid by me, and that photocopies of this form will be valid. I request that this information also apply to all other insurance. I understand that I am financially responsible for all charges, whether or not paid by the insurance carrier.

Signed: _____ Date: _____

**** Please be aware driving may be impaired following DILATION ****

2020 MEDICARE DEDUCTIBLE

Medicare participants have the annual financial obligation of meeting the $198.00 deductible as part of the contractual obligations of their insurance coverage. To eliminate collection confusion, Delray Eye Associates, PA requests the following from its Medicare patients:

1. **If you know that you have not met your annual deductible, it must be paid at the conclusion of your visit today.**

2. **If you believe you have already met your deductible or that your secondary carrier will pay the deductible in full, we require the authorization to charge your Visa, MasterCard or American Express should the $198.00 or any portion thereof be withheld from our reimbursement. Please complete the information below and present this form at checkout.**

3. **If you are unable to provide authorization for payment directly from your credit card, you must sign below which means you will make payment within 15 days of notification that the Medicare deductible was applied to Delray Eye Associates, PA services.**

I authorize Delray Eye Associates, P.A. to charge my credit card for any deductible amount imposed against their claim for services and any co-insurance amount that has not been paid by my secondary.

_____ _____

Signature **Date**

_____ _____

Visa/MasterCard/Amex # **Expiration Date**

_____

Print Name

_____

Billing Address

NOTICE OF PRIVACY PRACTICES FOR DELRAY EYE ASSOCIATES, P.A.

THIS NOTICE SUMMARIZES OUR *Health Insurance Portability and Accountability Act* POLICY CONCERNING HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

INFORMATION COLLECTED ABOUT YOU

In the ordinary course of receiving treatment and health care services from us, you will be providing us with personal information such as name, address, phone number, medical information, etc. We may also electronically obtain your personal medication history to assist in your treatment.

HOW WE MAY USE AND DISCLOSE INFORMATION ABOUT YOU

We may use and disclose personal and identifiable health information about you for treatment, for consultation with other health-care professionals, for payment from insurance companies, when required to by law, and for various other reasons which are fully explained in our complete HIPAA policy statement, *which is available to you upon request, and which we strongly urge you to review. There is a fee associated with providing you with a full copy.*

OTHER USES AND DISCLOSURES OF PERSONAL INFORMATION

We are required to obtain written authorization from you for any other uses and disclosures of medical information other than those described above. If you provide us with such permission, you may revoke that permission, in writing, at any time.

I authorize you to discuss my medical records and care with the following:

_____

_____

INDIVIDUAL RIGHTS

You have the right to ask for restrictions on the ways we use and disclose your health information for treatment, payment and health care operation purposes. You may also request that we limit our disclosures to persons assisting your care or payment for your care. We will consider your request, but we are not required to accept it. To exercise any of your rights, please contact us in writing at:

Leslie Bardt Buchanan
Practice Administrator
Delray Eye Associates, P.A.
16201 South Military Trail
Delray Beach, FL 33484

A COPY OF OUR COMPLETE HIPAA POLICY IS AVAILABLE FOR YOUR REVIEW. THERE IS A FEE ASSOCIATED WITH PROVIDING A COMPLETE COPY.

Patient signature _____