MANHATTAN EYE

www.manhattaneyenye.com
Yuna Rapoport, MD MPH

Date _____

PATIENT INFORMATION

Last Name _____ First _____ M.I. ____

DOB ____/____/____ Age _____ Sex M F Marital Status S M W D

Home Address _____ City _____ State ____ Zip _____

Home Phone (____) ____-____ Soc. Sec. # ____-____-____

Email _____

Your Employer _____ Occupation _____

Work Address _____ City _____ State ____ Zip _____

Work Phone (____) ____-____ Alternate Phone/Cell (____) ____-____

If you were referred by a physician, what is their specialty?

Recommended By _____ ☐ Ophthalmology ☐ Optometry ☐ Medicine ☐ Other

Address _____ Phone (____) ____-____

Your other physicians (Primary Care, Cardiologist, etc.)

Physician's Name	Specialty	Phone
		(____) ____-____
		(____) ____-____
		(____) ____-____

Pharmacy Name & Address _____ Phone (____) ____-____

Person Responsible for Bill (if other than yourself) ☐ Spouse ☐ Parent ☐ Guardian ☐ Other _____

Last Name _____ First _____ M.I. ____

Birth Date ____/____/____ Sex M F Soc. Sec. # ____-____-____

Home Address _____ City _____ State ____ Zip _____

Home Phone (____) ____-____ Cell Phone (____) ____-____

INSURANCE INFORMATION

Insurance #1 _____

Policy # _____ Group No. (or name) _____

Insured's Name _____ Relationship _____ DOB ____/____/____

Do you have secondary insurance? ☐ Yes ☐ No

Insurance #2 _____ Policy # _____

AUTHORIZATION

I hereby authorize the physicians indicated above to furnish information to insurance carriers concerning my illness, accident and/or treatments. I hereby assign to the above physicians all payments for medical services rendered to myself or to my dependents. I understand that I am financially responsible for all charges whether or not covered by insurance. A copy of this authorization shall be considered as effective and valid as the original.

Signature _____ Date _____

MANHATTAN EYE

Yuna Rapoport MD PC dba Manhattan Eye
PATIENT CONSENT FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Yuna Rapoport MD PC to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Notice of Privacy Practices provides a more completed description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Manhattan Eye PC reserves the right to revise its Notice of Privacy practices at any time. A revised Notice of Privacy Practices may be obtained by sending a written request to Anna Varshisky, Privacy Officer, 437 Fifth Avenue, Second Floor, NY, NY 10016.

With this consent, Manhattan Eye PC may call my home or other location and may leave a message on voicemail or answering machine or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and calls pertaining to my clinical care.

With this consent, Manhattan Eye PC may mail to my home or oher location any items that assist the practice in carrying out TPO, such as reminders, billing statements and medical information.

With this consent, Manhattan Eye PC may email any items that assist the practice in carrying out TPO.

By signing this form, I a m consenting to Manhattan Eye PC to use and disclosure of my PHI (Protected Health Information) to carry out TPO (Treatment, operations).

I may revoke my consent in writing except to the extent that the practice has already I made disclosures in reliance upon my prior consent. Ifl do not sign this consent, Manhattan Eye May not treat me.

Signature of Patient: _____ Date: _____

Print Patient Name: _____

MANHATTAN EYE

www.ManhattanEyeNYC.com

YUNA RAPOPORT MD, MPH

Patient Name: _____ Date of Birth: _____

AUTHORIZATION AND CONSENT

I hereby authorize that payment from my medical insurance program or my Medicare benefits be made to the above named physician on any unpaid bills for services provided on or after today. I also authorize any holder of medical or other information about me to release to their health care financing administration, its intermediaries, insurance companies, or their agents any information needed to determine benefits payable for services. I permit a copy of this authorization to be used in place of the original. I understand that I am financially responsible for any balance not covered by my insurance carrier.

NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosure of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practice's current Notice of Privacy Practices on Request.

_____ _____

Signature of patient or authorized representative Today's date

SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT

Patient Name: _____

MEDICARE PATIENTS: I request that payment by Medicare be made on my behalf to Dr. Rapoport for services furnished to me by Dr. Rapoport. I authorize my medical information about me to be released to Medicare and its agents and information needed to determine payable benefits. Dr. Rapoport accepts the charge determination of the Medicare carrier as full payment. I am responsible for deductibles, co-payments and non covered services.

MEDIGAP PATIENTS and/or SECONDARY INSURANCE (AARP, BLUE SHIELD, EMPIRE, GHI,ETC):
I understand that if! have secondary health insurance they will be billed after my primary insurance has paid. If Dr. Rapoport do not participate with my secondary insurance I aJh responsible for any balance due as well as deductibles, co-payments and non-covered services.

OTHER INSURANCE (OXFORD, AETNA, ETC.)
Dr. Rapoport maintains a list of health care service plans with whom she is contracted. If she is contracted with my plan, that insurance will be billed directly. I am responsible for any deductible, copay or co-insurance for non-covered services at the time services are rendered.

NON-COVERED SERVICES:
I understand that I am responsible for any non-covered services and accept full responsibility for all items and services if considered "not covered" by my insurance plan. THIS COULD INCLUDE BUT IS NOT LIMITED TO; REFRACTION, DIAGNOSTIC TESTING, TREATMENT AND OTHER SERVICES.

RELEASE OF INFORMATION:
Dr. Rapoport may disclose all or any part of my medical record and/or financial record which is necessary or appropriate in order to bill my insurance company. A copy of this signed authorization may be used in place of the original.

FINANCIAL AGREEMENT:
I agree that in return for the services provided to the patient by Dr. Rapoport, I will pay my account at the time services are rendered. If my account is sent to an attorney or collection agency, I agree to pay any expenses or attorney's fees, in addition to the past due account. I understand that if my account is delinquent I may be charged interest at the legal rate. It is understood that the undersigned and/or patient is the primary responsible person for the bill regardless of insurance.

Signature of Patient: _____ Date_____

MANHATTAN EYE

Yuna Rapoport, MD, MPH
Cataract and Refractive Surgery
Comprehensive Ophthalmology

Non-covered Services - Refraction Fee - $85

When we determine the glasses or contact lens prescription which provide you with the best corrected vision, your eyes have been "refracted". During the test, lenses are placed in front of the eye and the patient is asked, “Which is better one or two?”?

Medicare, and most other major insurance companies, consider refraction a non-covered service to be billed by physicians themselves. We are required to collect these fees if we provide the service, as failure to bill Medicare beneficiaries for non-covered services and deductibles is considered fraudulent.

A refraction fee is charged when a glasses or contact lens prescription is provided. However in some cases a refraction may be performed in order to determine the best corrected vision. It is customary to perform a refraction on all new patients.

Our office fee for a refraction is $85 and this fee is collected in addition to any co-payment at the time of service.

Contact lens fitting is a separate charge with a separate fee schedule (available at reception) depending on the contact lens type.

Acknowledgment
I have read the above information and understand that the refraction is a non- covered service. I accept full financial responsibility for the cost of this service. The copayment is separate from and not included in the refraction fee.

*Patient Signature (Parent for minor)*_____ *Date* _____

☐ I decline a refraction at this time. I understand that if I request a prescription for glasses or contacts, the refraction fee will be assessed.

Cancellation / Missed appointment Fee - $25

We understand that plans change and emergencies arise. Please notify us as soon as possible if you need to cancel or reschedule your appointment. Manhattan Eye has a 24 hour cancellation policy. This means that missed appointments or same-day cancellations or rescheduled appointments are subject to a **$25.00 Cancellation Fee** for office visits. These fees are applied whether or not you receive a reminder call or text from our office. They also apply to appointments made just one day in advance.

Please help us service you better by keeping scheduled appointments.