SEF
75 FROEHLICH FARM BLVD | WOODBURY, NY 11797 | 516.496.2122 PHONE
SCHLESSINGEREYEANDFACE.COM

PATIENT INFORMATION

NAME (Last, First, Middle)		SS#	BIRTHDATE	SEX
LOCAL ADDRESS		PATIENTS EMPLOYER		
CITY, STATE, ZIP		ADDRESS		
HOME PHONE	CELL PHONE	CITY, STATE, ZIP		
WORK PHONE		PHARMACY NAME & NUMBER		
E-MAIL ADDRESS:	PRIMARY CARE PHYSICIAN NAME & NUMBER			

INSURANCE INFORMATION

NAME (Last, First, Middle)	SS# REQUIRED	DOB REQUIRED	SEX
LOCAL ADDRESS	SECONDARY/BILLING ADDRESS (If Applicable)		
CITY, STATE, ZIP	CITY, STATE, ZIP		
HOME PHONE	HOME PHONE		
NAME OF PRIMARY INSURANCE	POLICY #		
NAME OF INSURED/RELATIONSHIP TO PATIENT	COPAY AMOUNT		
SECONDARY INSURANCE	POLICY #		
NAME OF INSURED/RELATIONSHIP TO PATIENT	COPAY AMOUNT		

HOW WERE YOU REFERRED TO OUR OFFICE?

- ❑ FAMILY / FRIEND NAME_____
- ❑ PATIENT NAME_____
- ❑ CASTLE CONNELLY TOP DOCTORS
- ❑ MAGAZINE _____
- ❑ OUR WEBSITE
- ❑ INTERNET SEARCH
- ❑ OTHER _____

REFERRING MD_____

WHO SHALL WE CALL IN CASE OF EMERGENCY? PLEASE GIVE NAME, RELATIONSHIP TO YOU AND PHONE #

IS ANYONE AUTHORIZED TO MAKE INQUIRIES TO OUR OFFICE ON YOUR BEHALF? IF SO, PLEASE PROVIDE THEIR NAME AND THEIR RELATIONSHIP TO YOU

NAME: RELATIONSHIP:

_____ _____

SIGNATURE OF PATIENT / GUARDIAN DATE

SEF

Name: _____ Date_____

Please list **ALL** medications you are currently taking (including herbal supplements/OTC's/etc.):

_____

_____

Any Allergies (medications, latex, shellfish, etc.) **YES / NO** .....Please list all below

_____

List Surgeries_____

Do you use: Tobacco: YES / NO Alcohol: YES / NO Recreational Drugs: YES / NO

How Much_____ How Much_____ List Drugs_____

Do you have the following?	Yes (√)	No (√)	If yes, please describe here:
Neurological disease or disorder			
Headaches			
Heart Disease			
High Blood Pressure			
Circulatory Problems			
Asthma or Bronchitis			
Diabetes			
Thyroid disease or other endocrine disorders			
Skin Diseases			
Gastro-intestinal Disorders			
Liver Disease			
Kidney Problems			
Arthritis or other joint/muscle diseases			
Bleeding Disorders			
Blood Clots			
Immune Disorders			
Psychiatric Problems			
Cancer or Tumors			
Prostate Problems (men)			
Obstetric or Gynecologic Problems (women)			
Sexually Transmitted Diseases			
Are you pregnant?			
Have you had surgery? (please list)			
Other problems listed above?			
Are immunizations up to date?			

SIGNATURE_____ DATE_____

SCHLESSINGER EYE & FACE | FINANCIAL, PHOTO & APPOINTMENT POLICIES

rev 9/2016

PLEASE PRINT FULL NAME _____ TODAY'S DATE _____

Thank you for selecting SCHLESSINGER EYE & FACE ("SEF") for your medical & cosmetic care. To prevent any misunderstandings concerning your financial responsibilities while obtaining care in our Practice, we request that you comprehensively read our Office Financial Policy prior to being seen by our Physicians and staff.

Patient or guarantor is financially responsible to make payment at the time all services are performed. The only exception to this rule will occur when the provider is participating with your HMO/PPO. In these cases, we will accept the insurance payment as payment in full ONLY AFTER all deductibles and copays have been paid by the patient or guarantor. If your insurance carrier requires additional copayments for diagnostic testing, it is your responsibility to make these payments. ***It is the responsibility of the patient to ensure that the physician you are seeing is indeed a participating provider with your plan.***

Please initial next to each bullet point below to illustrate your understanding:

_____ SEF does not "accept assignment" in lieu of collecting monies that may also be due from the patient.

_____ Our physicians DO NOT PARTICIPATE WITH MEDICAID.

_____ At the request of the patient, we can bill you for services; please be advised that we will add a $25 administrative charge to your bill for this convenience.

_____ All referrals must be obtained BY THE PATIENT **prior** to being seen by our specialist physicians.

_____ A $35 "no-show" fee will be charged for appointments not cancelled within 24 hours of appointment time

_____ A $35 returned check fee will be applied for any checks that are not cleared for payment by your bank.

_____ Medicare patients are responsible for their annual deductible every calendar year in addition to 20% of the approved Medicare fee that is not covered by Medicare

_____ For all services not covered by insurance including supplies, refractions and cosmetic procedures, payment is expected at the time of service. If you fail to give appropriate notice and fail to keep your appointment for an aesthetic procedure, any pre-paid deposits will be non-refundable.

During the course of your treatment, photos may be taken. Photos are taken to document treatment results and also to substantiate the medical necessity of insurance-related procedures. These photos may be requested in order to secure authorizations and approvals. These photos may also be used to illustrate results to other patients or in certain print and online marketing or other educational materials.

_____ YES. You have my permission to use my photos as described above.

_____ NO. I do not give my permission to use my photos as described above. As I have withheld my permission to share my photos, I realize this may negatively impact my ability to ensure proper authorization or permissions requested for medical procedures and I may be denied coverage for these.

I HAVE READ THE ABOVE AND FULLY UNDERSTAND THE FINANCIAL AND APPOINTMENT POLICIES OF THE OFFICE OF SCHLESSINGER EYE & FACE AS STATED. I FURTHER STATE THAT MY SIGNATURE ON THIS PAGE SIGNIFIES MY CONSENT TO FUTURE VERSIONS OF THIS AGREEMENT, UNTIL SUCH TIME THAT I AM GIVEN A NEW FORM TO SIGN.

_____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

SEF

RECEIPT OF NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT FORM

I, _____, have been given the
(PATIENT NAME – PLEASE PRINT)

opportunity to review a copy of the Notice of Privacy Practices for the practice of

SCHLESSINGER EYE & FACE.

_____
SIGNATURE OF PATIENT OR RESPONSIBLE GUARDIAN

_____
DATE