

**WELCOME**

Thank you for choosing our practice for your eye care needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance.

**PATIENT INFORMATION**

\_\_\_\_\_  
First Name MI Last Name

\_\_\_\_\_  
Address Apt. # City State Zip Code

Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_ Sex: Female Male  
Month Day Year

Social Security Number: \_\_\_\_/\_\_\_\_/\_\_\_\_ Occupation: \_\_\_\_\_

Marital Status: Married Widowed Single Separated Divorced Minor

Phone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Email: \_\_\_\_\_ Where may we contact you: Home Work Cell Email

Referred by: Doctor/Patient/Other \_\_\_\_\_ Phone: \_\_\_\_\_

**Are you interested in:** Laser Vision Correction (Ilasik) Vitamin Supplements LATISSE®  
BOTOX® for wrinkles and facial shaping Wrinkle Reduction/PrevageMD/VIVITÉ Skin Care

**GUARANTOR INFORMATION**

\_\_\_\_\_  
First Name MI Last Name

\_\_\_\_\_  
Address City State Zip Code

\_\_\_\_\_  
Social Security Number Date of birth Telephone Number

**INSURANCE INFORMATION**

Medicare BC/BS Oxford Aetna Cigna Multiplan PHCS Medicare & Medicaid  
Medicare & AARP United Healthcare 1199 Other \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group number: \_\_\_\_\_

Provider Telephone #: \_\_\_\_\_ Member Telephone #: \_\_\_\_\_

**IN CASE OF EMERGENCY CONTACT**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_ Work: \_\_\_\_\_

**DISCLOSURE OF MEDICAL INFORMATION**

I hereby authorize Dr. Douglas F. Buxton to furnish any and all of my records, history and treatment given to me for purpose of review, investigation or any evaluation of any claim submitted to my insurance company. This authorization shall become effective immediately and shall remain in effect for the duration of any term of coverage including a reasonable time thereafter. This authorization shall be binding upon me, my dependents, heirs, executor and administrators

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED  
HEALTH INFORMATION**

I hereby give my consent for *Buxton Eye Surgical Group* to use and disclose protected health information (*PHI*) about me to carry out treatment, payment and healthcare operations (*TPO*). (*Buxton Eye Surgical Group* Notice of Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. *Buxton Eye Surgical Group* reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to *Buxton Eye Surgical Group* at 310 East 14<sup>th</sup> Street, Suite 403, New York, NY 10003.

With this consent, *Buxton Eye Surgical Group* may call my home or other alternative location and leave a message of voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointments reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, *Buxton Eye Surgical Group* may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, *Buxton Eye Surgical Group* may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that *Buxton Eye Surgical Group* restrict how it uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to ***Buxton Eye Surgical Group***'s uses and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, ***Buxton Eye Surgical Group*** may decline to provide treatment to me.

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Signature of Patient or Legal Guardian

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Patient's Name

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Print Name of Patient of Legal Guardian

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Date

# *Buxton Eye Surgical Group*

## Financial Policy

We are committed to providing you with the best possible medical care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve this goal, we need your assistance and your understanding of our financial policy.

### **SELF PAY**

Payment for services is due in full on the day the services are rendered. We accept cash, check, MasterCard or Visa. If we do not participate in your insurance plan, we will be happy to help you process your insurance claim once you have paid your bill in full.

A completed insurance form must accompany any such request for each visit. Returned checks will be subject to a \$40 service charge.

### **INSURANCE**

Please be aware that your insurance policy is a contract between you and the insurance company. As medical providers, our relationship is with you and not with your insurance company. While the filing of insurance claim forms is a courtesy we extend to our patients, all charges are your responsibility from the date the services are rendered. You are expected to know and follow all regulations or procedures as agreed to by you and your insurance company regarding referrals, second opinions or pre-certification. We will assist you in obtaining pre-certification for services as needed. Failure to obtain this information or if you provide incorrect information (wrong insurance company, invalid policy number, etc.) may result in the denial of your claim, and you will be held responsible for the balance. Any out-of-pocket expenses such as the deductible and coinsurance/co-payments must be paid at the time of service. If you belong to any restricted "HMO" (needing a referral from your Primary Care Physician), we cannot see you without a referral unless you pay for the visit yourself. Being aware of your insurance company's policies, requirements and restrictions are your responsibility.

Your insurance company may not cover certain tests considered necessary by your eye doctor. Under these circumstances, with your prior consent, you will be financially responsible for the costs of such tests.

**I realize that all office visits are to be paid at the time services are rendered, unless prior arrangements for a financial plan have been made. I authorize the release of any medical information necessary to process my insurance claims. I consent to photography if medically indicated and authorize release of payments for medical benefits to be made directly to Buxton Eye Surgical, P.C.**

Please note that all patients who miss a scheduled appointment without cancelling or rescheduling with this office with 24 hours notice will be subject to a **\$50.00 "NO SHOW FEE"** at the next visit.

I have read and fully understand the policies of this practice regarding payments and insurance. I agree to pay for services and tests not covered by my insurance plan when appropriately informed. I understand that I am responsible for following my insurance plan's regulations, policies and procedures. A \$30.00 re-submission fee will be charged if the insurance information you provide to us is incorrect or invalid (i.e., coverage has been terminated or changed), and you want us to re-submit your claim.

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Patient's Signature/Guarantor's Signature

Date

# Buxton Eye Surgical Group

**Douglas F. Buxton, M.D., FACS**

310 East 14<sup>th</sup> Street, Suite 403

New York, NY 10003

212-979-4410

**www.buxtoneye.com**

Patient Name \_\_\_\_\_

Date \_\_\_\_\_

**NOTE: Your Medical Insurance Plan, including Medicare, doesn't pay for services listed in the box below. The fee is collected at the time of service in addition to any co-payment your plan may have.**

**•Please, choose an option below if you wish to receive any of the services listed.**

I do not wish to receive any of the services listed below

SERVICE	FEE
<input type="checkbox"/> Refraction: <b>measures prescription for glasses.</b>	\$100.00
<input type="checkbox"/> Regular Contact lens fitting, <b>new fit, includes instruction on insertion and removal of contact lenses, pair of contact lenses, prescription for glasses and contact lenses, one-two follow up visit for any possible modification of lens.</b>	\$250.00
<input type="checkbox"/> Multi Focal Contact lens fitting, <b>new fit, includes instruction on insertion and removal of contact lenses, pair of contact lenses, prescription for glasses and contact lenses, one-two follow up visit any possible modification of lens.</b>	\$375.00
<input type="checkbox"/> Toric(astigmatism) Contact lens fitting, <b>new fit, includes instruction on insertion and removal of contact lenses, pair of contact lenses, prescription for glasses and contact lenses, one-two follow up visit any possible modification of lens.</b>	\$300.00
<input type="checkbox"/> Re-fit regular contact lens, <b>your current contact lenses are evaluated for correctness of fit, power and material; prescription for glasses and contact lens is dispensed.</b>	\$150.00
<input type="checkbox"/> Re-fit Toric contact lens, <b>your current contact lenses are evaluated for correctness of power and material; prescription for glasses and contact lens is dispensed.</b>	\$200.00
<input type="checkbox"/> Re-fit Multifocal contact lens, <b>your current contact lenses are evaluated for correctness of fit, power and material; prescription for glasses and contact lens is dispensed.</b>	\$300.00
<input type="checkbox"/> Other	

## PATIENT ACKNOWLEDGMENT

**I have read the above information and understand that the refraction and/or contact lens fitting is a non-covered service. I accept full financial responsibility for the cost of this services and understand it is due at time of service. I understand that any copayment, coinsurance, or deductible I may have are separate and not included in this fee.**

\_\_\_\_\_  
Patient Signature

**Signature on file, Assignment of Benefits**

\_\_\_\_\_  
Beneficiary Name(Print)

\_\_\_\_\_  
Medicare Number

Effective Date: \_\_\_\_\_

- **MEDICARE:** I request that payment of authorized Medicare benefits to be made on my behalf to Buxton Eye Surgical Group, for service furnished me by Buxton Eye Surgical Group. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. Of other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Buxton Eye Surgical Group accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.
- **MEDIGAP:** I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes services release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Buxton Eye Surgical Group, if possible or otherwise to me.
- **OTHER INSURANCE:** I understand that Buxton Eye Surgical Group maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office. And that Buxton Eye Surgical Group has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Buxton Eye Services Group if I belong to a plan that services rendered to me by Buxton Eye Surgical Group if I belong to a plan that does not appear on the mentioned list.

\_\_\_\_\_  
**Beneficiary Signature or Authorized Party**