Buxton Eye Surgical Group

Douglas F. Buxton, M.D., FACS
310 East 14th Street, Suite 403
New York, NY 10003
212-979-4410
www.buxtoneye.com

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 ☐Other
Month Day Year

Social Security Number: _______ /__________/__________ Occupation: _________________

Marital Status: ☐Married ☐Widowed ☐Single ☐Separated ☐Divorced ☐Minor

Phone: Home: ____________________Work: ___________________Cell: ______________________

Email: ________________________ How May We Contact You: ☐Home ☐Work ☐Cell ☐Email

Referred by: Doctor/Patient/Other ______________________________ Phone:______________________

Race: ___________ Ethnicity: ____________ Language Spoken: ____________

POLICY HOLDER INFORMATION (If different than patient)

____
First Name MI Last Name

____
Address City State Zip Code

_______/_______/_________ ____/_____/____ ________________________________
Social Security Number Date of birth Telephone Number

INSURANCE INFORMATION

Please provide insurance card to front desk.

PHARMACY INFORMATION

Pharmacy Name: _________________________Telephone Number:__________________________

IN CASE OF EMERGENCY CONTACT

Name: ______________________________Relationship: ___________________________________
Phone: ______________________________Cell: ____

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: ________________________

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NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT

DATE: _______________

I acknowledge that I was provided with a copy of the Buxton Eye Surgical PC Notice of Privacy Practices.

__________________________ __________________________

Patient Name Patient Signature

If Completed by a patient's a personal representative, please print and sign you name in the space below.

_______________________ ___________________________ ___________________________

Personal Representative (Print) Representative's Signature Relationship

HIPPA PATIENT RESTRICTION

Please list individual(s), friends or family, if any, who you would allow any medical information released to. This authorization will allow the release of any and all medical and billing information to the individuals listed on this form. It is not necessary to list your physician office here.

1. Name:_________________________________ Relationship: __________________________
2. Name: ________________________________ Relationship: ___________________________
3. Name: ________________________________ Relationship: ___________________________

For Buxton Eye Surgical PC use only

Complete this section if this form is not sign and dated by the patient or patient personal representative.

I have made a good faith effort to obtain a written acknowledgement of receipt of Buxton Eye Surgical PC Notice of Privacy Practices but was unable to unable to for the following reason:

□Patient Refused to Sign

□Patient unable to sign

□Other____________________

Employee Name ________________________ 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. 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, Visa, American Express, and Discover. 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

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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
Refraction: measures prescription for glasses.	$150.00
Regular Contact lens fitting, 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.	$300.00
Multi Focal Contact lens fitting, 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.	$450.00
Toric(astigmatism) Contact lens fitting, 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.	$375.00
Re-fit regular contact lens, your current contact lenses are evaluated for correctness of fit, power and material; prescription for glasses and contact lens is dispensed.	$225.00
Re-fit Toric contact lens, your current contact lenses are evaluated for correctness of fit, power and material; prescription for glasses and contact lens is dispensed.	$275.00
Re-fit Multifocal contact lens, your current contact lenses are evaluated for correctness of fit, power and material; prescription for glasses and contact lens is dispensed.	$375.00
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 these services and understand that payment 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. The prescription will be valid for 12 months and adjustments will be covered within 6 months upon dispensing.

____

Patient Signature

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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 o 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.

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Beneficiary Signature or Authorized Party