



Samuel Yankelove, MD

EYE LASER SPECIALISTS PATIENT INFORMATION

___ New Patient ___ Returning Patient

Patient Name: _____ Date of Birth: _____ Age _____ Male/Female

Address: _____
Street City State Zip

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Your Social Security No: _____ Your Employer: _____

Referred by: Primary Care Physician Optometrist Friend/Relative Other

Name: _____

Address: _____
Street City State Zip

Medical Insurance (if applicable)

Plan Name: _____ Insured Name: _____

ID#: _____ Date of Birth: _____

Primary Insured SS#: _____ Employer: _____

Vision Insurance (if applicable)

Plan Name: _____ ID/SS#: _____

NOTIFICATION OF PATIENT RESPONSIBILITY FOR FEES

Some procedures, such as routine eye exams, measuring for glasses, contact lens fitting, special testing, cosmetic procedures and refractive surgeries, **MAY NOT BE COVERED BY INSURANCE.**

Payment of these services is your responsibility and must be paid for on the date of service.

If you have routine vision coverage, or think that you may be covered, please notify the receptionist on or before the date of service. This is necessary for us to comply with the terms of your plan.

While we make every effort to verify your coverage and file your insurance claim, the insurance company has the right to deny your claim. Should we receive notification that your claim has been denied for lack of coverage for the service, **payment of services is your responsibility.**

Assignment and Release: I request that payment of authorized Medicare or private insurance benefits are made on my behalf to Samuel J. Yankelove, M.D for any services furnished to me by those physicians. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS), private insurance and their agents any information needed to determine these benefits or benefits payable for related services. This signature will be an "on file" authorization to file future forms with Medicare and other insurance companies and for the treatment of myself and/or my minor children. I am financially responsible for non-covered services.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

Signature: _____ Date: _____

Print name: _____



Samuel Yankelove, MD

Permission to Release Health Information

Date: _____

I, the undersigned patient, give permission to release medical information as requested, regarding my eye health and prescriptions to the individuals listed below:

_____ and/or _____

My relationship to the above listed individual(s) is as follows (please circle the appropriate answer(s)):

Parent Wife Husband Son Daughter

Optometrist _____

Other _____

Patient Signature

Date