Rosenthal Eye Surgery/Rosenthal Facial Plastic Surgery
Kenneth J Rosenthal, MD Surgeon, Director

310 East Shore Road Suite 102
Great Neck, NY 11023

310 East 14th Street Suite 403
New York, NY 10003

Patient Registration Form

Name:____ ☐ Jr ☐ Sr
Last *First* *Middle Initial*

Sex: ☐ Male ☐ Female

Title: ☐ Mr. ☐ Mrs. ☐ Dr. ☐ Ms. ☐ Miss

Address: ____
Street # *Street Name* *Apt #*

____
City *State* *Zip*

Date of Birth:________________
M D Y

Social Security #:____________________

Home Phone:____________________ **Cell Phone #**: ____________________

Email:______________________________ **Fax #:**____________________

Primary Care Physician:________________________ **PCP Phone #:**____________________

PCP Address:____

If Student: ☐ Full Time ☐ Part Time **Name of School**:____________________

Employer:________________________ **Work Phone**:____________________
Name

Work Address:____

Marital Status: Single: ☐ Married: ☐ Divorced: ☐ Widow: ☐

Spouse's Name:________________________ **Spouse's Date of Birth**:________________
M D Y

Referred By:____
Name *Phone Number*

We routinely send reports to your primary care physician; please list any other health care provider you wish us to send copies of these reports to:

____
Dr.'s Name *Phone* *Fax*

____
Dr.'s Name *Phone* *Fax*

____
Dr.'s Name *Phone* *Fax*

Patients Signature:______________________________ **Date:**________________

Patient's Name:_______________________________ **DOB:**______________ **Today's Date:** _____________

Do we have your permission to leave information related to your medical care:

Leave a message on your answering machine at home? ☐ Yes ☐ No
Leave a message at your place of employment? ☐ Yes ☐ No
Discuss your medical condition with any member of your household? ☐ Yes ☐ No
If yes, with whom:_____________________________ Relationship:_____________________________

Insurance Information

Primary	Secondary
Primary Insurance Name:_______________________	Secondary Insurance Name:_____________________
Name of Policy Holder:__________________________	Name of Policy Holder:________________________
Patient's ID #:_________________________________	Patient's ID #:________________________________
Group #:______________________________________	Group #:_____________________________________
Patient's Relationship to Policy Holder:______________	Patient's Relationship to Policy Holder:______________
Insurance Address:______________________________	Insurance Address:_____________________________

Policy Holder Information (If Different from Patient)

Name:_______________________________________ Relationship:____________________________
Address:_____________________________________ Home Phone:_____________________________
Social Security #:_______________________________ Date of Birth:____________________________

Pharmacy of Choice:___________________________ **Phone #**:________________________________

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (HIPAA)

I give my consent to, Kenneth J. Rosenthal, M.D., P.C. to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Kenneth J. Rosenthal M.D., P.C.'s Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have been offered the opportunity to view or have in fact viewed the complete Privacy Practice Notice on file in this office. I acknowledge receipt of the Notice of Privacy Practices prior to signing this consent. Kenneth J. Rosenthal, M.D., P.C. 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 Kenneth J. Rosenthal, M.D., P.C. Privacy Officer.

I give my consent to, Kenneth J. Rosenthal, M.D., P.C. to call my home or other designated location and leave a message on voice mail in reference to any items and any call pertaining to my clinical care, including laboratory results among others.

I give my consent to, Kenneth J. Rosenthal, M.D., P.C. to mail to my home or other designated 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.

I give my consent to, Kenneth J. Rosenthal, M.D., P.C. to e-mail to my home or other designated 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 Kenneth J. Rosenthal M.D., P.C. 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 Kenneth J. Rosenthal M.D., P.C.'s use and disclosure of my PHI to carry out TPO.

Patients Signature:____ **Date:**___________________

Patient's Name:________________________________ **DOB:**______________ **Today's Date:** _____________

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, Kenneth J. Rosenthal, M.D., P.C. may decline to provide treatment to me.

REASON FOR YOUR VISIT

Please Note: If your visit is for a "check up" not related to a medical condition or symptom (e.g. irrirated eyes, decreased vision, flashes of light, diabetes, cataract, headaches) your insurance company does not cover those types of services. You will be expected to pay for that type of visit.

- ☐ Consultation for cataract surgery
- ☐ Consultation for eyelid or facial plastic surgery (or laser wrinkle removal)
- ☐ Consultation for refractive surgery (to correct nearsightedness or astigmatism)
- ☐ If referred by your internist for evaluation of a specific condition, please explain:

  ____

- ☐ Referred by your general ophthalmologist, optometrist, optician or by a plastic surgeon for consultation
- ☐ Other (Please specify):____

Do you have any allergies? ☐ Yes ☐ No **If yes**, please list:

1.______________________ 2.______________________ 3.______________________

List all medications you are currently taking (including over the counter): **None:** ☐

1.______________________ 2.______________________ 3.______________________

4.______________________ 5.______________________ 6.______________________

Do you drink alcohol? ☐ Yes ☐ No If Yes _______ drinks per day

Do you smoke? ☐ Yes ☐ No If yes, how much:_______ cigarettes per day

What is your occupation?___________________________________

What sports, if any, do you participate in?__________________________________

Do you wish to change or improve your facial appearance?

☐ Facial wrinkles ☐ Drooping or heavy eyelids ☐ Under eye bags

Are you interested in BOTOX or fillers for your forehead, crows feet, around your mouth or your neck?

☐ BOTOX ☐ Fillers ☐ Both

Are you interested in surgery or treatment to reduce/eliminate your need for glasses?

☐ Yes ☐ No

Patients Signature:____ **Date:**_____________________

Patient's Name:_______________________________ **DOB:**______________ **Today's Date:** _____________

YOUR MEDICAL HISTORY: (check "normal" if no medical condition applies)

Do you have now, or have you ever had diseases or conditions of:

General Fever: ☐ Weight Loss: ☐ Weight Gain: ☐ Fatigue: ☐ Dizziness: ☐

Normal: ☐ Other: ______________________________

ENT Sinus: ☐ Decreased Hearing: ☐ Recent Dental Work: ☐ Cosmetic surgery/treatment: ☐

Normal: ☐ Other: ______________________________

Skin Skin Disease: ☐ Breast Cancer: ☐ Rosacea: ☐ Keloid Formation: ☐

Normal: ☐ Other: ______________________________

Lungs Asthma: ☐ Bronchitis: ☐ Lung Cancer: ☐ TB: ☐ Pneumonia: ☐

Normal: ☐ Other: ______________________________

Heart Hypertension: ☐ Heart Attack: ☐ Pacemaker: ☐ Bypass Surgery: ☐ Failure: ☐

Normal: ☐ Other: ______________________________

GI Ulcer: ☐ Gall bladder: ☐ Liver: ☐ Colon Cancer: ☐ IBD: ☐

Normal: ☐ Other: ______________________________

Urinary Kidney Transplant: ☐ Kidney Stones: ☐ Dialysis: ☐ Prostate Cancer: ☐

Normal: ☐ Other: ______________________________

Glands Thyroid Disease: ☐ Pituitary Tumor: ☐ Diabetes: ☐

Normal: ☐ Other: ______________________________

Blood Anemia: ☐ Easily Bleed: ☐ Clots: ☐ Sickle Cell: ☐ HIV/AIDS: ☐ Cholesterol: ☐

Normal: ☐ Other: ______________________________

Muscles & Bones Arthritis: ☐ Myalgia: ☐ Osteoporosis: ☐ Hip Replacement: ☐

Normal: ☐ Other: ______________________________

Neurological Headaches: ☐ MS: ☐ Stroke: ☐ Seizure: ☐ Migraines: ☐

Normal: ☐ Other: ______________________________

Psychiatric Depression: ☐ Mental Retardation: ☐

Normal: ☐ Other: ______________________________

FAMILY HISTORY

Has any member of your family had these diseases: (Please check only if applies)

Cancer: ☐ Heart Disease: ☐ Diabetes: ☐ COPD: ☐ Hypertension: ☐ Stroke: ☐

Lazy/crossed eye: ☐ Glaucoma: ☐ Macular Degeneration: ☐ Blindness: ☐ Retina Problems: ☐

Patients Signature:_______________________________ **Date:**______________

Patient's Name:_______________________________ **DOB:**______________**Today's Date:** _____________

Cataracts: ☐ Eye Surgeries: ☐ What Type:______________________________

YOUR EYE RELATED HISTORY

☐ Yes ☐ No **Have you ever had any serious eye injury or operation, or have you been treated for any serious medical condition for the eyes?**

If yes, Please explain:____

Have you recently or persistently experienced and of the following symptoms:

☐ Yes ☐ No Flashes of Light

☐ Yes ☐ No Floaters

☐ Yes ☐ No Double Vision

Have you experienced decreased vision in one or both eyes during the following activities? (Please check only if applies)

☐ Yes ☐ No Reading, sewing, or doing other close work?

☐ Yes ☐ No Driving or seeing road signs?

☐ Yes ☐ No Performing tasks needed for your work?
Please specify:____

☐ Yes ☐ No Excessive glare, particularly with point sources of light (ie. Headlights) or in bright light?

☐ Yes ☐ No Difficulty seeing in normal or dim light?

☐ Yes ☐ No Persistent eye pain

☐ Yes ☐ No Excessive tearing

Have you even been told that you have:

☐ Yes ☐ No Cataracts

☐ Yes ☐ No Glaucoma

☐ Yes ☐ No Retina Problems (ie. Retinal detachment, macular degeneration)

☐ Yes ☐ No Any other eye disease?
Please specify:____

Do/Did you wear glasses for: Distance vision: ☐ Near vision: ☐

Do you wear contact lenses: (if yes, check all that apply) Hard:☐ Soft:☐ Daily wear:☐ Extended wear:☐

Do you wear sunglasses? ☐ Yes ☐ No

Has your driver's license ever been suspended, restricted or revoked because of vision impairment? ☐ Yes ☐ No

Patients Signature:____ **Date:**____________________

Patient's Name:________________________________ **DOB:**______________**Today's Date:** _____________

Social Security Number:_____________________________________

Kenneth J. Rosenthal, MD PC
Signature on File, Assignment of benefits, Financial Agreement for All Insurances

1. **Insurance:** I request that **payment authorized insurance benefits be made on my behalf to Kenneth J. Rosenthal, MD PC** for services furnished to me by Kenneth J. Rosenthal MD PC, I authorize any holder of medical information about me to release to my insurance company 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. If 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. Kenneth J. Rosenthal, MD PC accepts the charge determination of the Insurance carrier as the full charge for covered services only, and **I am responsible only for the deductible, coinsurance and non-covered services**, subject to provisions listed elsewhere in this document, and **payable at the time of the visit**. Co-insurance and deductible are based upon the charge determination of the Insurance Carrier.
   Initials:_____________

2. **Secondary/Medigap Insurance**: I request that payment of authorized secondary/medigap insurance benefits be made on my behalf to Kenneth J. Rosenthal, MD PC if possible or otherwise to me. **I assert that I have declared all insurance under which I am covered** in the patient questionnaire that I completed separately.
   Initials:_____________

3. **Release of Information:** Kenneth J. Rosenthal, MD PC may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to Kenneth J. Rosenthal, MD PC for reimbursement for services rendered, and (2) any health care provider for continued patient care. Kenneth J. Rosenthal, MD PC may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation. A copy of this authorization may be used in place of the original.
   Initials:_____________

4. **Other Insurance:** I understand that Kenneth J. Rosenthal, MD PC maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office. Kenneth J. Rosenthal, MD PC has no contract, expressed or implied, with any plan that does not appear on the list. I understand that **I am individually obligated to pay the full charges of all services rendered to me by Kenneth J. Rosenthal, MD PC if I belong to a plan that does not appear on the above mentioned list, or if my policy has lapsed or otherwise does not cover services rendered by the practice.** I understand that I am obligated even if there is an error in determining coverage, either on my part or on the part of the practice, at the time of the visit or before or after the visit. **Initials**:______________

5. **Non-Covered Services**: I understand that Kenneth J. Rosenthal, MD PC contracts with health care service plans (i.e. HMO's, PPO's) only for items and services which are "covered" by the health care service plans and that the practice provides many services above and beyond "standard" insurance covered care. Accordingly, **the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered.** Examples of non covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient; and treatment or tests not authorized by the health care service plan. My signature below shall be considered to be my durable acknowledgement that I have been informed of all non-covered charges and that I agree to pay the practice directly for them. The undersigned agrees to cooperate with Kenneth J. Rosenthal, MD PC to obtain necessary health care service plan authorizations. **Initials**:_____________

Patients Signature:____ **Date:**____________________

Patient's Name:_________________________________ **DOB:**_______________**Today's Date:** ______________

Social Security Number:________________________________

Kenneth J. Rosenthal, MD PC
Signature on File, Assignment of benefits, Financial Agreement for All Insurances

6. FINANCIAL AGREEMENT: I agree that in return for the services provided to the patient by Kenneth J. Rosenthal, MD PC, and in order to leave Dr. Rosenthal and his staff free to dedicate their efforts towards my best care, **I will pay my account at the time of service**. ***I understand that Kenneth J. Rosenthal MD PC does not bill and that there will therefore be a $25 charge per twice monthly billing cycle should I fail to pay at the time of the visit, or if not presented at the visit, if I do not pay within 5 days of the first time payment is requested either verbally or in writing.*** If an account is sent for collection or legal proceeding, I agree to pay a processing fee of $200 plus all expenses and attorney's fees. I understand and agree that if my account is delinquent, I will be charged interest at the legal rate in addition to the billing fee. Any benefit of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to Kenneth J. Rosenthal, MD PC. *However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.* If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Kenneth J. Rosenthal, MD PC at the time of the visit.
Initials:_____________

7. CANCELLATION AND NO SHOWS: I understand that the practice has set aside time especially for me in order to provide me with dedicated, attentive and skilled care. In the event that I must cancel any appointment I agree to provide at minimum 48 hours advance notice for such change, and that I must speak directly to a practice representative regarding the cancellation. I understand that surgical appointments are non-cancelable once booked. In the even that these requirements are not met, I agree to pay an amount equal to full private pay fee of the practice for such services.
Initials:_____________

8. GROUP CONTRACT RELEASE: If my coverage is under a Group Contract held by an employer, an association, trust fund, union, or similar entity, this authorization also permits disclosure to them for purposes of utilization review or audit. **Initials**:_____________

9. **DURATION OF THIS AGREEMENT:** This authorization shall become effective immediately upon execution and shall remain in effect for the duration of any claim or term of coverage with all insurance companies including a reasonable time thereafter, until its final consummation.
Initials:_____________

This authorization shall be binding upon me, my dependents, and my heirs, executors and administrators

Patients Signature:____ **Date:**_____________________