TO ALL OF OUR PATIENTS

If your insurance requires referrals or pre-authorization, it is YOUR RESPONSIBILITY to obtain these Please advise us of any changes in your medical history, insurance, address and phone number.

MEDICARE Authorization

I request that payment of authorized MEDICARE benefits be made either to me or on my behalf to Kinnelon Eyecare for any services furnished to me by either Dr Niki Patellis or Dr Barbara Koslow. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents, any information needed to determine these benefits or the benefits payable for related services.

Date__/__/__ Signature of Patient/Guardian_______________________________________

Please PRINT Patient's name____

COMMERCIAL Authorizaton

I authorize that payment for authorized insurance benefits be made either to me or on my behalf to Kinnelon Eyecare for any services furnished to me by either Dr Niki Patellis or Dr Barbara Koslow. I authorize any holder of medical information about me to release to said insurance company and its agents any information needed to determine these benefits or the benefits payable for related service.

Date __/__/__ Signature of Patient/Guardian_______________________________________

Please PRINT Patient's Name____

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have had the opportunity to read a copy of Dr Niki Patellis' and Dr Barbara Koslow's

NOTICE OF PRIVACY PRACTICES

Date__/__/__ Signature of Patient/Guardian_______________________________________

Please PRINT Patient's Name____

If Applicable:

I give Kinnelon Eyecare permission to discuss my medical history with the following designated person(s):

____Relation:______________________________

____Relation:______________________________

____Relation:______________________________