IRENE MAGRAMM, M.D., P.C
220 EAST 63RD STREET, SUITE LM
NEW YORK, NY 10065
(212)-644-5100

DATE: _____

LAST NAME: _____ FIRST NAME: _____

ADDRESS: _____APT#_____

CITY: _____ STATE:_____ZIP:_____

TELEPHONE: _____CELL: _____

EMAIL: _____

DATE OF BIRTH: _____ SEX: M / F (Circle One)

PRIMARY INSURANCE: _____ ID#_____

SECONDARY INSURANCE:_____ID#_____

GUARDIAN: _____ RELATIONSHIP: _____

PRIMARY CARE DOCTOR: _____

HOW WERE YOU REFERRED: _____

PRIVACY NOTICE:

I AUTHORIZE THE ROUTINE RELEASE OF MY MEDICAL INFORMATION FOR THE PURPOSE OF TREATMENT, BILLING AND ROUTINE HEALTHCARE OPERATION SUCH AS QUALITY ASSURANCE MONITORING. I UNDERSTAND THAT MY MEDICAL INFORMATION WILL NOT BE RELEASED FOR ANY PURPOSE WITHOUT MY CONSENT.

INSURANCE OR MEDICARE AUTHORIZATION

I REQUEST THAT PAYMENT OF AUTHORIZED HEALTHCARE BENEFITS BE MADE DIRECTLY TO DR. IRENE MAGRAMM FOR SERVICES RENDERED. I AUTHORIZE THAT ANY MEDICAL INFORMATION NEEDED TO DETERMINE BENEFITS PAYABLE ARE RELEASED TO MY HEALTHCARE INSURANCE COMPANY.

(Make any additions below in assigned colored ink and sign & date)

SIGNATURE _____ DATE _____ FIRST VISIT (Blue/Black Ink)

SIGNATURE _____ DATE _____ 2nd VISIT (Red Ink)

SIGNATURE _____ DATE _____ 3rd VISIT (Green Ink)

PARTICIPATING INSURANCE WAIVER

The staff of Dr. Irene Magramm will help you in any way we can to make sure your insurance company reimburses appropriately for all covered services and at the correct level of reimbursement. Individuals and companies other than your physician determine any requirements for pre-authorization, referrals and/or limitations of coverage.

I therefore agree to accept responsibility for co-payments, deductibles, co-insurance and any medical care I agree to undergo, which is not covered by my insurance. If medical care is rendered based upon the wrong insurance plan due to inaccurate information provided at the time of my visit, I also agree to assume full financial responsibility for those services denied.

REFRACTION is an important test which determines the focusing ability of your eyes. It allows the doctor to more completely examine your eyes, to check and prescribe eyeglasses, if needed, and to help in the treatment of many eye muscle and lazy eye problems. Your insurance may not cover this test.

If a refraction test is performed under Medicare, 1199, or Anthem, etc., you will be expected to make payment, at the time of your visit. This is not reimbursed by your insurance.

The fee is $100.00 for refraction (Code 92015).

For those other insurances that deny coverage for refraction (Code 92015) during the billing process, our office will bill you upon insurance coverage denial.

For example, some of the following insurance companies that do not cover Refraction:

1199
Medicare
Other insurances (to be determined by your policy and insurance company)

If your insurance carrier does not pay for the above procedure, you will be responsible for the refraction payment fee on date of service.

PLEASE NOTE:

There is a $35.00 fee for less than 72-hour appointment cancellation or appointment no-show.

Motor Vehicle Form	**$35.00**
School Form	**$20.00**

I understand my responsibility for full payment for the above: (Date & Sign for each visit)

	1st Visit (Blue/Black Ink)	2nd Visit (Red Ink)	3rd Visit (Green Ink)
Patient name:	_____	X_____	X_____
Signature:	_____	X_____	X_____
Date:	_____	X_____	X_____

GENERAL	YES	NO	EXPLANATION OF PROBLEM
ALLERGIES (Please list)			
Are you pregnant?			
Do you smoke (If yes, how much?)			
Do you drink (If yes, how much?)			
Fevers/ Weight Loss or Fatigue			
EYES			
Lazy Eye (Amblyopia)			
Crossed Eyes (Strabismus)			
Glaucoma			
Cataracts			
Eye Surgery			
EAR, NOSE & THROAT			
Sinusitis or Nasal Allergies			
Hearing Loss			
HEART / CIRCULATION			
Slow or Irregular Heartbeat			
Heart Murmur or Heart Failure			
Chest Pain (Angina) or Heart Attack			
Heart Surgery			
LUNGS / BREATHING			
Asthma/Bronchitis/Emphysema			
Tuberculosis			
KIDNEY / BLADDER			
Kidney Stones			
BLOOD / LYMPH NODES			
Bleeding Tendency or Easy Bruising			
Sickle Cell			
SKIN			
Eczema/Psoriasis or Skin Cancer			
DIGESTIVE/ MUSCULOSKELETAL			
Peptic Ulcer / Hiatal Hernia			
Arthritis			
ENDOCRINE			
Diabetes or Thyroid Condition			
FAMILY HISTORY			
Cataracts			
Glaucoma			
Macular Degeneration			
Retinal Disease			
Diabetes			
Alcoholism/ Obesity or Thyroid Disease			

List all MEDICATIONS That Are Being Taken NOW, Including Eye Drops

Have you had any SURGERIES or INJURIES? If YES, please tell us what kind and when.

	1st Visit (Blue/Black Ink)	2nd Visit (Red Ink)	3rd Visit (Green Ink)
Pt/Parent Signature	_____	X_____	X_____
MD Signature:	_____	X_____	X_____
Date:	_____	X_____	X_____