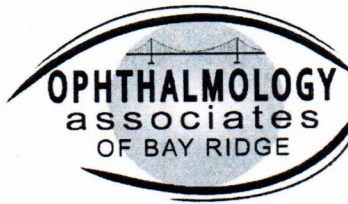


Elias Aliprandis, MD  
Irene Rusu, MD  
Brian Herschorn, MD



8721 4<sup>th</sup> Ave., Brooklyn, NY 11209  
Phone: (718) 680-1500  
Fax: (718) 680-5550

NAME: \_\_\_\_\_  
(LAST NAME) (FIRST NAME) (M.I.)

DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_

ADDRESS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

HOME PHONE #: \_\_\_\_\_

CELL PHONE #: \_\_\_\_\_

WORK PHONE #: \_\_\_\_\_

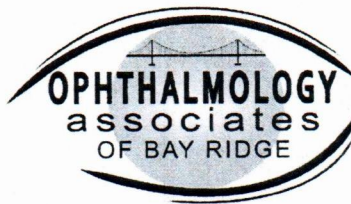
EMAIL ADDRESS: \_\_\_\_\_

**PROVIDING YOUR EMAIL ALLOWS YOU TO ACCESS TO OUR PATIENT PORTAL,  
WHICH IS REQUIRED BY THE GOVERNMENT. YOU WILL RECEIVE AN INVITATION TO  
REGISTER FOR THE PORTAL, WHICH ENABLES YOU TO ACCESS YOUR MEDICAL  
RECORDS, PAY A BILL, MAKE AN APPOINTMENT, OR SEND A MESSAGE TO OUR OFFICE.  
WE DO NOT SELL YOUR EMAIL ADDRESS TO ANYONE!!!**

EMERGENCY CONTACT NAME: \_\_\_\_\_

EMERGENCY CONTACT PHONE NUMBER: \_\_\_\_\_

Elias Aliprandis, MD  
Irene Rusu, MD  
Brian Herschorn, MD



8721 4<sup>th</sup> Ave., Brooklyn, NY 11209  
Phone: (718) 680-1500  
Fax: (718) 680-5550

### CONSENT FOR MINOR ACCOMPANIMENT

I \_\_\_\_\_ father/mother/legal guardian of \_\_\_\_\_  
Allow my child to be examined without my being there. My child will be accompanied  
by \_\_\_\_\_ who is the child's \_\_\_\_\_  
Relationship

I give full permission and responsibility to the person accompanying my child to make  
all final decisions for today's visit at Ophthalmology Associates of Bay Ridge.

Please present a copy of your ID and ID of the person who is accompanying the child.

Parent's Name: \_\_\_\_\_

Parent's Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Telephone: \_\_\_\_\_

Witness Signature: \_\_\_\_\_

(staff member at OABR)

## **NOTICE OF \$30 FEE FOR NEW EYEGLOSS PRESCRIPTIONS**

If you would like a new prescription for eyeglasses, we must perform a REFRACTION. Refraction is the procedure that a trained ophthalmic professional performs to determine a person's exact eye glass prescription. This is a SEPARATE service performed at the time of your eye examination which is **not always covered by insurances**. If your insurance does not pay for refraction, we will collect a nominal \$30.00 fee for this service.

**Insurances that always pay for refraction:** Elderplan, Health First, HIP and Health Plus WILL pay eye care professionals for this service and therefore, there will be NO refraction charge for patients with these insurances.

**Insurances that sometimes pay for refraction:** Aetna, Americhoice, BlueCross/ Blue Shield, Healthnet, Magnacare, Oxford and United Health Care will SOMETIMES pay eye care professionals for this service and therefore, we will bill the insurance company first. If they do send us a payment, there will be NO bill sent to you. If they refuse to pay for this service, then a bill for \$30 will be sent to you.

**Insurances that do not pay for refraction:** Medicare, AARP, 1199 National, Amerigroup, Atlantis, Cigna, Emblem Health, Empire Plan, GHI, Healthcare Partners and Medicaid say the refraction service is the patient's responsibility and they will NOT pay for this service. For patients with these insurance plans, there will be a \$30 refraction charge due on the day of your visit, if this service is performed.

\*\*\*\*\*

Please indicate that you have read the following statement:

**I understand that if I want and receive a new prescription for eyeglasses, I will be charged \$30.00 if my insurance does not cover this service.**

Patient, parent or guardian's signature: \_\_\_\_\_

Relation to patient: \_\_\_\_\_ Date: \_\_\_\_\_

**\*\*\*This acknowledgement applies to today's office visit and all subsequent visits.**

Dear Patient:

Ophthalmology Associates of Bay Ridge ("OABR") respects the privacy of your health information.

In order to provide you with quality health care, we may try to call you on the phone before or after your visit, as well as speak with you in person, while you are here. Sometimes, these face to face conversations may occur when a member of your family, a friend or another escort is with you. Sometimes you may not be home when we call and we will want to either leave a message for you to call us back or we may want to speak with someone else.

The purpose of this notice is to **give you the opportunity to let us know about any restrictions you want us to follow in our communicating with you as part of our providing you with health care.** *Please check the appropriate boxes below* (and provide us with specific guidance as to how to communicate with you privately, if appropriate):

**No restrictions:**

\_\_\_\_\_ OABR staff can speak with me in the presence of my family member(s), friend(s) or other individual(s) who accompany me.

\_\_\_\_\_ OABR staff may leave messages for me or speak with someone else at the phone number(s) I have provided if I am not available to come to the phone myself.

**Restrictions:**

\_\_\_\_\_ When I am in the doctor's office, please speak to me about my care **ONLY** when my family member(s) or other escort(s) **CANNOT** overhear the conversation.

\_\_\_\_\_ OABR staff may **NOT** leave call back messages for me at the number(s) I have provided.

\_\_\_\_\_ OABR staff may **NOT** speak with anyone else at the phone number(s) I have provided.

\_\_\_\_\_ Other comments or requests regarding the privacy of my health information:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_.

\_\_\_\_\_  
patient signature

\_\_\_\_\_  
date

**OPHTHALMOLOGY ASSOCIATES OF BAY RIDGE, P.C.**

**PRIVACY NOTICE SUMMARY**

**THIS SUMMARY NOTICE OUTLINES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

**WE ARE LEGALLY OBLIGATED TO MAINTAIN THE PRIVACY OF PROTECTED HEALTH INFORMATION, TO PROVIDE THIS NOTICE OF PRIVACY PRACTICES AND TO ABIDE BY THE TERMS OF THIS NOTICE. WE RESERVE THE RIGHT TO CHANGE OUR PRIVACY PRACTICES. THIS NOTICE IS EFFECTIVE AS OF APRIL 14, 2003. YOU CAN REVIEW THE FULL VERSION OF THIS NOTICE BY ASKING THE RECEPTIONIST FOR A COPY OF IT.**

- 1. Protected health information ("PHI") is information relating to your health status or treatment as well as information relating to your health insurance, billing or payment for your health care.**
- 2. We will only use or disclose your PHI for purposes of our treating you, verifying your insurance, billing your insurance company, processing payments from that insurance company or in our performance of other necessary business functions. We will only use or disclose the minimum information necessary in order to accomplish the intended purpose. We will not use nor disclose you PHI for any other reason without your specific authorization to do so.**
- 3. You have the right to inspect and receive a copy of your PHI, for as long as we maintain it.**
- 4. You have the right to request restrictions on how we use or disclose your PHI.**
- 5. You have the right to request that we amend your PHI, if you believe that it is inaccurate.**
- 6. You have the right to request that we communicate with you by non-routine means or at an alternative location.**
- 7. If we even ask you to authorize us to use your PHI for any reason other then treatment, insurance verification, billing payment or other necessary business functions and you give that authorization, you have the right to revoke that authorization at a later date, as well as to receive an accounting of any disclosures or uses we have made, pursuant to your authorization.**
- 8. Any questions or complaints you may have regarding this notice or our privacy practices should be addressed to Dr. Elias Aliprandis, who can be reached at: 718-680-1500.**

**I HAVE RECEIVED A COPY OF THIS PRIVACY NOTICE:**

---

patient signature

---

date

dir:HIPPA.sum.notice.OABR