New Paltz Eye Care
Elinor B Descovich, OD, PC

188 Main Street
New Paltz, NY 12561
845.255.8370
Fax 845.255.6329

SIGNATURE ON FILE

I authorize the release of any medical or other information necessary to process an insurance claim on my behalf. I also request payment of benefits to myself or to "Elinor B Descovich, OD, PC" should they agree to accept assignment for services provided to me.

If "Elinor B Descovich, OD, PC" agrees to accept assignment, the physician or supplier agrees to accept the charge determination of the carrier as the full charge and the patient is responsible for only the deductible, co-insurance, and non covered services. Co-insurance and the deductible amount are based upon the charge determination of your insurance carrier.

I understand that I am financially responsible for any charges not covered by my plan.

Signed: _____

Print: _____

Date: _____

TREATMENT/HIPAA RELEASE

I consent to this office's use and disclosure of my protected health information to carry out my treatment, payment, and healthcare. I have been given a copy of the office health information privacy practices (you can revoke this consent with written notice).

Signature:_____Date:_____

All patients: Dilating drops may be needed as part of your eye health exam. Blurry reading vision and light sensitivity can last a few hours. If you do **NOT** want this test done, please initial here_____.