DR. ANDREA THAU & ASSOCIATES
DOCTORS OF OPTOMETRY
77 PARK AVENUE
NEW YORK, NY 10016
TELEPHONE: (212) 685-2457
FAX: (212) 685-5989

WELCOME TO OUR OFFICE

REFERRED BY: _____

PATIENT NAME: _____ SS#: _____
ADDRESS: _____ APT#: _____
CITY/STATE/ZIP: _____ HOME PHONE#: (____) _____
CELL PHONE#: (____) _____ EMAIL: _____
WORK PHONE#: (____) _____ WORK FAX#: _____
DATE OF BIRTH: _____ MARITAL STATUS: S M SEP D W
EMPLOYER NAME: _____ OCCUPATION: _____
WORK ADDRESS/CITY/STATE/ZIP: _____
EMERGENCY CONTACT: _____ RELATION: _____
HOME PHONE#: (____) _____ WORK PHONE#: (____) _____

INSURED'S INFORMATION (IF NOT THE PATIENT)

NAME: _____ RELATION: _____
ADDRESS/CITY/STATE/ZIP: _____
HOME PHONE#: (____) _____ DATE OF BIRTH: _____ SS#: _____
EMPLOYER: _____ WORK PHONE#: (____) _____

INSURANCE INFORMATION

PRIMARY INSURANCE NAME: _____ EFFECTIVE DATE: _____
ADDRESS: _____
PHONE#: (____) _____ ID#: _____ GROUP#: _____
SECONDARY INSURANCE NAME: _____ EFFECTIVE DATE: _____
ADDRESS: _____
PHONE#: (____) _____ ID#: _____ GROUP#: _____

FINANCIAL ARRANGEMENTS AND INSURANCE

- Co-payments, co-insurance, deductibles, all previous balances, non-covered services and amount exceeding your annual maximum are due at the time of service.
- If your insurance requires you to have a referral at the time of the visit, it is your responsibility to obtain the referral. If you do not have one at the time of service, you are required to pay for the visit in full.
- Returned checks are subject to a **$40.00 FEE.**
- Routine eye examinations, refractions, contact lens fittings, contact lens evaluations and vision therapy are **NOT COVERED** by most insurance plans/companies.
- There is a **$30.00 CANCELLATION FEE** for failure to cancel within **24 hours** prior to your appointment. Except for visual evaluations/perceptual appointments, there is a **$75.00 CANCELLATION FEE** for failure to cancel these appointments within **48 hours** prior to your appointment.
- Visual Skills Evaluations and Visual Perceptual Evaluations are **NOT COVERED** by any insurance plans/companies.

AUTHORIZATION FOR ASSIGNMENT OF BENEFIT

I HEREBY AUTHORIZE DRS. ANDREA THAU, FRAN REINSTEIN, MARILYN VRICELLA, AND/OR ERICA SCHULMAN AND/OR TO APPLY FOR BENEFITS ON MY BEHALF FOR COVERED SERVICES RENDERED BY THEM. I REQUEST THAT PAYMENT FROM MY INSURANCE COMPANY BE MADE DIRECTLY TO DRS. ANDREA THAU, FRAN REINSTEIN, MARILYN VRICELLA, AND/OR ERICA SCHULMAN. I CERTIFY THAT THE INFORMATION I HAVE REPORTED WITH REGARDS TO MY INSURANCE COVERAGE IS CORRECT. I ACKNOWLEDGE THAT I AM RESPONSIBLE FOR THE PAYMENT OF THE ENTIRE BILL IF MY INSURANCE COMPANY DOES NOT COVER ANY SERVICES RENDERED.

PLEASE BE SURE YOU HAVE READ THIS DOCUMENT VERY CAREFULLY.

I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL.

SIGNATURE: _____ DATE: _____