

Oculoplastic Surgeons of Philadelphia

Telephone: (610) 649-1970	(267) 928-2798	Fax (610) 649-8624	Website: www.phillyeyeplastics.com	
<u>Wynnewood, PA 19096</u>	<u>Philadelphia, PA 19106</u>	<u>Marlton, NJ 08053</u>	<u>Media, PA 19063</u>	<u>Northfield, NJ 08225</u>
Lankenau Hospital	The Curtis Center	775 Route 70 East	Ophthalmic Partners	Northfield Office
54 Medical Bldg. East	601 Walnut Street, Ste L60	Bldg. F-180	319 W. State Street	1500 Tilton Road

DATE: _____

To My Patient

Since your last visit, has any of the following changed?

- | | | |
|--|-----|----|
| 1. Do you have a living will or Power of Attorney? | YES | NO |
| 2. Do you have a change of Insurance? | YES | NO |
| 3. Do you have a change in Pharmacy? | YES | NO |
| 4. Do you have a change in address? | YES | NO |
| 5. Do you have a cell phone we can put on file? | YES | NO |
| 6. Have you had a COVID VACCINE in the past 2 years? | YES | NO |

Signature of patient

Thank you for allowing us to update your patient chart.

Sincerely,

Dr's Carrasco, Rabinowitz, Watson, Penne, and Stefanyszyn

Wills Eye Oculoplastic Surgeons

Mary A. Stefanyszyn, M.D., F.A.C.S.	Jacqueline R. Carrasco, M.D., F.A.C.S.
Robert B. Penne, M.D., F.A.C.S.	Michael P. Rabinowitz, M.D., F.A.C.S.
Alison H. Watson M.D., F.A.C.S.	

Distinguished Emeritus

William H Annesley, Jr., M.D.
Joseph C. Flanagan, M.D., F.A.C.S.

Oculoplastics Eyelid, Lacrimal and Orbital Disorders/Surgery

Financial Responsibility Assignment of Benefit and Patient Authorization

Charges for Items of Services

I am financially responsible to the extent permitted by applicable law to pay to Annesley, Flanagan, Stefanyszyn, and Penne & Associates all charges for Items or services rendered to Patient. This expressly includes any insurance deductibles, Co-insurances, co-payments and non-covered services. I acknowledge that the information provided is accurate and complete. If there are any changes to this information in the future, I will provide any such changes at my next scheduled visit.

Assignment of Benefits

I hereby authorize and assign payment directly to Annesley, Flanagan, Stefanyszyn, Penne & Associates for medical insurance benefits otherwise payable to me under the terms of my policy, but not exceed the balance due to Annesley, Flanagan, Stefanyszyn, Penne & Associates for Items rendered to the Patient.

Release of Health Information

I authorize Annesley, Flanagan, Stefanyszyn, Penne & Associates disclose any or all parts of Patient's medical record to the Patient's insurance company(s) or employer(s) for the purpose of satisfying charges billed by Annesley, Flanagan, Stefanyszyn, Penne & Associates for Items or services provided by the Patient. I further understand that it may be necessary for Annesley, Flanagan, Stefanyszyn, Penne & Associates to contact my past or present employer regarding this claim. This authorization does not cover third party liability claims.

I hereby release and forever discharge Annesley, Flanagan, Stefanyszyn, Penne & Associates and its respective employees, directors, officers, shareholders, agents, assigns and legal representative (collectively, Annesley, Flanagan, Stefanyszyn, Penne & Associates Parties) from any and all obligations, claims, liabilities, damages, debts, liens and deficiencies arising out of or in connection with Financial Responsibility, Assignments of Benefits and Patient Authorization ("Authorization"). I hereby agree to indemnify and hold harmless Annesley, Flanagan, Stefanyszyn, Penne & Associates from and against any liability, loss, cost or expense (including reasonable attorney's fees) incurred by Annesley, Flanagan, Stefanyszyn, Penne & Associates in reliance upon this Authorization.

I permit a copy of this Authorization to be used in place of the original. I certify that this information is true complete to the best of my knowledge.

Patient Signature

Date

DOB

Responsible Party Name (if applicable)

Date

Responsible Party Signature (if applicable)

Date

Please describe responsibility Party relationship to Patient: _____

Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rules

Acknowledgement of Receipt of Notice of Privacy Practices

By signing below I acknowledge that Annesley, Flanagan, Stefanyszyn, Penne and Associates has provided me with access to its Notice of Privacy Practices, as required under the Health Insurance Portability and Accountability Act of 1996.

Charges for Items of Services

I am financially responsible to the extent permitted by applicable law to pay Annesley, Flanagan, Stefanyszyn, Penne and Associates all charges for items and services rendered to patient. This expressly includes any insurance deductibles, co-insurance, co-payments and non-covered services. I acknowledge that the information provided is accurate and complete. If there are any changes to this information in the future, I will provide any such changes at my next scheduled visits.

Patient Signature/ or Patient's Personal Representative

Date

DOB