CANCELLATION/NO SHOW POLICY

(MUST BE FILLED OUT IN BLACK INK)

Your appointment time is reserved especially for you. Please cancel your scheduled appointment at least 24 hours in advance if you are unable to keep it. This allows our office to offer that time to another patient. If you forget or fail to show up for your appointment without giving us 24-hour notice, there will be a $75.00 fee charged to your account. The same applies to appointments cancelled with less than 24-hour notice. Thank you for your cooperation and understanding.

PATHOLOGY LABORATORY SERVICES

If a surgical procedure is done on you in our office or in the hospital, your specimen may be processed at one of the two following locations…

1.) New York Presbyterian
Hudson Valley Hospital
1980 Crompond Road
Cortlandt Manor, NY 10567
914.737.9000

2.) The New York Eye & Ear Infirmary
310 East 14th Street
New York, NY 10003
212.979.4156

3.) Columbia University
Section of Dermatopathology
630 West 168th Street, VC 15-207
New York, NY 10032
212.305.4840

RELEASE OF INFORMATION

I authorize the release I authorize the release of medical records, any related studies, and other information to my family physician, the doctor from whom I am referred, my legal counsel and to the applicable third-party payer.

PHOTOGRAPH CONSENT

I agree that Dr. Kayvan Keyhani or designated representatives or the practice may take and use pre-treatment, pre-operative, post-treatment and post-operative photographs of my person for confidential clinical record purposes, and that such photographs shall remain the property of Keyhani Eye Associates.

Please read and sign the financial disclosure below…

1. I hereby authorize the release of medical information to my insurance company concerning my medical condition and treatment for the purpose of claim payment.
2. I assign Keyhani Eye Associates ALL payments from my insurance company for medical services rendered to myself and dependents.
3. I agree that if my insurance company sends payment to me for the medical services instead of Keyhani Eye Associates, I will immediately pay the amount due to Kayvan Keyhani, M.D.
4. I agree it is my responsibility to understand my insurance benefits and to notify Keyhani Eye Associates immediately of any changes to my insurance coverage.
5. I fully understand that I am financially responsible for any co-payments, deductibles, and co-insurance, cosmetic or non-covered services as determined by my insurance carrier.

A copy of this letter will remain signed in our chart as proof of this understanding.

_____ _____

PATIENT SIGNATURE (Please sign in black ink) DATE