

Brian N. Campolattaro, M.D. · Sarah A. McCord, M.D.  
30 East 40<sup>th</sup> Street Suite 405  
New York, NY 10016

**Please Print Clearly and Answer All Questions**

**Name of Patient** \_\_\_\_\_  
Patient's Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_  
Apartment # \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home phone ( \_\_\_\_\_ ) \_\_\_\_\_  
Cell - Parent 1 ( \_\_\_\_\_ ) \_\_\_\_\_  
Cell - Parent 2 ( \_\_\_\_\_ ) \_\_\_\_\_  
Name - Parent 1 \_\_\_\_\_  
Name - Parent 2 \_\_\_\_\_  
Email \_\_\_\_\_

**Patient is: Male** \_\_\_\_\_ **Female** \_\_\_\_\_  
Please list first and last names of physicians  
**Primary Physician** \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone ( \_\_\_\_\_ ) \_\_\_\_\_  
**Referring Physician** \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone ( \_\_\_\_\_ ) \_\_\_\_\_

**Please present your insurance card(s) to the receptionist so we can make copies for our records!**

**Primary Insurance** \_\_\_\_\_  
Policy Holder Name \_\_\_\_\_  
Group # \_\_\_\_\_  
Policy # \_\_\_\_\_  
Patient Relationship to Policy Holder \_\_\_\_\_  
Policy Holder Date of Birth \_\_\_\_\_  
Policy Holder Social Security # \_\_\_\_\_  
Phone No. on Back of Card for Providers \_\_\_\_\_

**Secondary Insurance** \_\_\_\_\_  
Policy Holder Name \_\_\_\_\_  
Group # \_\_\_\_\_  
Policy # \_\_\_\_\_  
Patient Relationship to Policy Holder \_\_\_\_\_  
Policy Holder Date of Birth \_\_\_\_\_  
Policy Holder Social Security # \_\_\_\_\_  
Phone No. on Back of Card for Providers \_\_\_\_\_

**AUTHORIZED SIGNATURES**

I hereby authorize Brian N. Campolattaro, M.D. or Sarah A. McCord, M.D. to release information concerning my care, treatment and the cost of said care and treatment to my insurance company and/or other third party administrator which may be responsible for payment of care and treatment.

I also authorize payment directly to Brian N. Campolattaro, M.D. or Sarah A. McCord, M.D. for healthcare benefits and agree that in the event that the cost of the treatment is not fully reimbursed by my insurance company and/or other third party payer, that it shall be my personal responsibility to pay Brian N. Campolattaro, M.D. or Sarah A. McCord, M.D. for the full cost of the services rendered. I agree that I am responsible for my percentage of benefit that the insurance company deems my responsibility.

I understand refraction may not be covered by my insurance company and I will be responsible.

Regardless of my Health Insurance benefits and status, I understand and agree that the cost of care and treatment remains my personal financial responsibility. I also agree to pay all responsible costs of collecting amounts due for services rendered under this agreement, including attorney's fees and legal expenses. I understand that if I want to know the cost of any service, it will be provided to me.

I understand that there is a \$40.00 fee for appointments not canceled within 24 hours prior to their scheduled time.

I acknowledge that I have been offered a copy of the Notice of Privacy Practices used by Brian N. Campolattaro, M.D. and Sarah A. McCord, M.D. regarding their use and disclosure of My Protected Health Information.

\_\_\_\_\_  
PATIENT/RESPONSIBLE PARTY

\_\_\_\_\_  
DATE