Daniel Laroche M. D.

EYE PHYSICIAN AND SURGEON, GLAUCOMA SPECIALIST
PRESIDENT, ADVANCED EYECARE OF NEW YORK

215-43 Jamaica Avenue
Queens Village, NY 11428
718-217-0424/ fax 718-217-0459

www.advancedeyecareny.com

49 West 127th Street
New York, NY 10027
212-663-0473/fax 917-493-1010

Clinical Assistant Professor Ophthalmology, Mount Sinai Hospital
Glaucoma and Anterior Segment Surgeon, New York Eye & Ear
Director Glaucoma, AENY, Aff. St. Lukes/Roosevelt Hospital

Fellow American Academy of Ophthalmology
Member, New York and American Glaucoma Society
Diplomat, American Board of Ophthalmology

To Our Patients:

We have implemented electronic medical records and electronic practice management to move to a paperless environment. This will make the office more efficient for your medical eye care and green for the environment.

You are being asked to completely fill this credit card authorization form which will be scanned into and held securely in our computer system. This form will then be shredded. We will bill your insurance first. If your insurances then make a determination of the amount of your patient responsibility (such as additional co-pay, co-insurance, deductible, etc.) the remaining balance owed by you will be billed to you first. You will have 60 days to settle your account. After 60 days any remaining balance will be charged to your credit card and a receipt will be mailed to you. We will also use this information to cover “no-show” fees.

We are moving away from mailing out paper statements after 60 days. This will be an advantage to you since you will no longer have to write out and mail us checks. We will benefit in that it will greatly decrease the number of statements that we have to generate and send out- we would rather focus on providing excellent service to you.

This in no way will compromise your ability to dispute a charge or an insurance company’s determination of payment.

Co-pays due at the time of the visit will still be due at the time of the visit.

Respectfully yours,
Advance Eye Care Of New York
Daniel Laroche MD

I authorize Advance Eye Care Of New York (Daniel Laroche MD PC) to charge outstanding balances on my account (not covered or pay by my insurance) to the following credit card or bank card.

Card: Visa ___ MasterCard ___ American Express ____ Discover ________________

Account number: ________________________________ Exp date: _______________

Billing zip code: ______ security code (4-digits for Amax and 3 digits for others):_____

Name as it appears on the card (please print):__________________________________

Name of patient same as above: ____ other (please print):________________________

Signature:____________________________________ date:______________________

Or please check below and sign above if applicable:
___ By my own solemn oath I do not have a credit card or bank card, I agree to pay for any outstanding balance I am responsible for according to my insurance plan/policy or if my insurance does not pay for services that have been rendered.