Michael L. Levine, M.D., F.A.C.S.

Michael L. Levine, M.D.
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Boynton Beach FL 33436
www.michaellevinemd.com

Phone: 561-733-3010
Fax: 561-733-0039
frontdesk@michaellevinemd.com

Date:_____

Last Name:_____ First Name:_____

Address:_____

Sex:_____ Date of Birth:_____ Marital Status:_____

Cell Phone:_____ Home Phone:_____

Email:_____

Appt Reminder Preference: ☐ Home Phone Call ☐ Cell Phone Call ☐ Cell Phone Text ☐ Email

Current Appt Reminder Preference:_____

Referral Source:_____

Family Doctor:_____

Primary Insurance:_____ ID#:_____

Secondary Insurance:_____ ID#:_____

Tertiary Insurance:_____ ID#:_____

Dilating Eye Drops:

Dilating drops are used to dilate or enlarge your pupils. This allows the Ophthalmologist a full view of the inside of your eye. Dilating drops will blur your vision for a length of time that varies from person to person and might make bright lights bothersome or painful to look at. It's not possible for an Ophthalmologist to know how this will affect your vision. After your dilated exam driving may be difficult. As a result, you may want to make arrangements for transportation before your exam.

Refraction:

All refractions are best effort, given as a courtesy and come with no guarantees. We highly recommend getting a refraction at the same place you purchase your glasses to help minimize any issues with your new glasses. The office is not financially responsible for any mistakes or issues that can occur from the refraction we give to patients.

PLEASE TURN OVER AND SIGN

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Harry A. Hamburger, M.D., M.S.
Christopher S. Castello, O. D.

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Prescriptions:

Due to the complexities of insurance it can be very complicated prescribing medicine. The office is not financially responsible for any issues regarding the cost of your medication with your pharmacy.

Patient Financial Responsibility:

I recognize, understand, and accept that I am financially responsible to the doctor for all charges, balances, or fees not covered in the event I have no insurance, my insurance is rejected, or the doctor is out of network. I understand that Dr. Levine does not accept and is out of network with all Medicaid plans and I will be responsible for any outstanding balance. I understand that if for any reason my insurance company does not pay my bill in ninety days, I will be financially responsible. I also understand that I am responsible for any deductible, copayment, or coinsurance and will be collected when I check in for my appointment.

Release of Information:

I hereby authorize Michael L. Levine, M.D., F.A.C.S. to release information acquired in the course of my examination and treatment to my insurance company, or patient's employer if Workman's Compensation.

Communication:

I hereby authorize Michael L. Levine, M.D., F.A.C.S. to contact me via phone, text, mail, and email regarding but not limited to appointment reminders, billing information, my treatment, medication and surveys.

Appointment Wait Time:

I recognize, understand, and accept that the wait time in the office can exceed 2 hours at times. That every patient has different medical needs and the doctor will spend the necessary time with each patient. The office has no way of estimating how long your wait time will be.

Appointment Changes:

Due to the complicated nature of our schedule your appointment might be changed to a different doctor with short notice.

Acknowledgement:

I acknowledge that the privacy practices of this office are available upon request. I attest that I have read and understand the Patient Registration form. All questions regarding this form have been answered.

PLEASE SIGN

X_____

Patient's Signature **Date**