Rudrani Banik, M.D., PLLC

950 Fifth Avenue
New York, N.Y. 10075

605 Park Avenue 1B
New York, N.Y. 10065

Tel: (646) 820-2074
Fax: (877) 900-4708

info@rudranibanikmd.com
www.rudranibanikmd.com

Dear Patient,

Welcome to the office of Rudrani Banik, M.D.

Dr Banik specializes in Neuro-Ophthalmology, Migraine Wellness, and Comprehensive Ophthalmology. The office address is:

950 Fifth Avenue
(corner of 76th Street)
New York, N.Y. 10075

605 Park Avenue
(corner of 65th Street)
New York, N.Y. 10075

Tel: (646) 820-2074
Fax: (877)-900-4708

Your appointment may last several hours. You will receive a complete neuro-ophthalmic exam by Dr. Banik and diagnostic testing, if necessary. We ask that you arrive to your appointment 15 minutes early.

In order to keep your appointment running smoothly, we have attached some forms for you to fill out before your visit. On the day of your appointment, please bring the following with you:

1. Office Registration Form, signed and dated.
2. Privacy Form, signed and dated.
3. Patient Responsibility Form, signed and dated.
4. Record Release Form, signed and dated.
5. Prior medical or ophthalmic records which are pertinent to your eye condition. This may include: referring doctor's clinical notes, bloodwork results, MRIs and Cat Scans (**CD ROMs with reports)

Please remember that Dr Banik does not participate with insurance carriers. You will be responsible for payment in full at the completion of your visit. Personal checks or cash are preferred, but credit cards are also accepted. For all credit card transactions, there will be a 2.75% processing fee added to your bill.

In case you need to reschedule or cancel your appointment, please notify the office 48 hours in advance. If you have any further questions regarding your appointment with us, please feel free to contact us.

We look forward to meeting you!

Rudrani Banik, M.D., PLLC

950 Fifth Avenue
New York, N.Y. 10075

605 Park Avenue 1B
New York, N.Y. 10065

Tel: (646) 820-2074
Fax: (877) 900-4708

info@rudranibanikmd.com
www.rudranibanikmd.com

New Patient Registration Form

Today's Date:	Primary Care Physician:		
PATIENT INFORMATION			
☐Mr. ☐Mrs. ☐Dr. ☐Miss. ☐Ms.	Last Name: (Legal Name)	First:	Middle:
	Marital Status (circle one):	Single / Married / Divorced / Separated / Widowed	
Birth date:	Age:		Sex:
Street Address:		Tel Home: Cell:	
P.O. Box:	City:	State:	Zip Code:
Occupation:	Employer:		Employee Phone No:
Pharmacy Name, Address and Telephone No:			
Allergies to Medications:			

Choose reason for visit:

☐ Neuro-Ophthalmology ☐Comprehensive Ophthalmology ☐Migraines

☐Botox ☐Other___________________________

Referred to practice by:

☐ Dr. _____________________________________ ☐Hospital ☐Family ☐Friend

☐ Close to home/work ☐ Internet Search (i.e., Google, Yahoo) ☐Prior Patient

☐ Social Media ☐Other____________________________

Other family member(s) seen here:

INCASE OF EMERGENCY		
Name of local friend or relative:	Relationship to patient:	Telephone No: Work No:

The above information is true to the best of my knowledge. I understand that I am financially responsible for the full balance at the time of service. I also authorize RUDRANI BANIK, M.D., PLLC 950 Fifth Avenue New York, N.Y. 10075 to release any information required to process out of network reimbursement claims to my insurance.

Patient/Guardian Signature Date

Rudrani Banik, M.D., PLLC

Notice of Privacy Practices

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

At Rudrani Banik, M.D., PLLC, we always keep your health information secure and confidential. A law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.

- The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.
- We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.
- We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.
- We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.
- We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.
- In an emergency, we may disclose your health information to a family member or another person responsible for your care.
- We may release some or all of your health information when required by law.
- If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.
As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.

You have the right to transfer copies of your health information to another practice. We will mail your files for you.

You have the right to see and receive a copy your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies.

You have the right to request an amendment or change to your health information. Give us your request

to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

You have the right to receive a copy of this notice.

If we change any of the details of this notice, we will notify you of the changes in writing.
You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, Washington, DC 20201. You will not be retaliated against for filing a complaint.
However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact Rudrani Banik, M.D. at 646-820-2074.

This notice goes into effect as of March 15, 2017.

Acknowledgement

I have received a copy of the Rudrani Banik, M.D., PLLC Notice of Privacy Practices.

Date ________________________

Signed ____

Print Name ____

If signing as a parent or guardian, please note the name of the patient

____

Rudrani Banik, M.D., PLLC

CONSENT FORM OF PATIENT RESPONSIBILITY

I hereby authorize Rudrani Banik, M.D., PLLC to provide me with medical services. I understand all expenses related to care and services provided by Dr Banik are my responsibility and liability.

I understand that Dr Banik does not participate with any insurance carriers. I am responsible for any and all balances due. I also understand that it is my responsibility to pay in full at the completion of my visit.

*DATE*_______________________________

PATIENT NAME (Printed) ____

*PATIENT SIGNATURE*____________________________________

Rudrani Banik, M.D., PLLC

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby authorize all of my medical records (including imaging, laboratory and ancillary testing results) to be sent to Rudrani Banik, M.D., PLLC at the following address:

Rudrani Banik, M.D., PLLC
950 Fifth Avenue
New York, N.Y., 10075
Tel: (646) 820-2074
Fax: (877) 900-4708

PATIENT NAME (Printed) ____

PATIENT DATE OF BIRTH ____

*PATIENT SIGNATURE*____

*DATE*____