MacQuaid Eye Institute VISION AND BEAUTY

Last Name: _____ First Name: _____ MI: ____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____ Work # _____

Email: _____ Do you want to be added to our email list? Yes ___ No ___

Date of Birth: _____/_____/_____ Gender: _____Male _____Female

Marital Status: Single _____ Married _____ Divorced _____ Widowed _____

Medical Insurance Name: _____ ID #: _____Group #: _____

Employment Status: ___ Child ___ Disabled ___ Full-Time ___ Part Time ___ Retired ___ Not Employed

Place of employment: _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Phone Number: _____

Responsible Party (Guarantor) Information ** If Self, please skip the below information

Relationship to patient: _____ Self _____ Spouse _____ Child _____ Other

Last Name: _____ First Name: _____ MI: ____

Mailing Address : _____City: _____

State: _____ Zip: _____ Date of Birth: _____/_____/_____

Home # _____ Cell #: _____ Work # _____

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Patient's Name: _____ Date: _____

Referring Doctor: _____ Primary Care Doctor: _____

Please list pharmacy name and zip code Name: _____ Zip: _____

OCULAR HISTORY:

Date of last eye exam: _____

Reason for today's visit (please circle or write in): _____

- Eye Lid lesion
- Stye
- Bell's Palsy
- Cosmetic/Botox/Filler
- Thyroid Disease
- Droopy Upper/Lower lids – Brow lift
- Skin Cancer
- Tearing
- Dry Eye

MEDICAL HISTORY:

Please List all Medications and dose:

_____

_____

_____

_____

Please List all Surgeries you have had:

_____

_____

_____

MEDICATION ALLERGIES:

- ☐ Penicillin
- ☐ Sulfa Drugs
- ☐ Other: _____

Social History:

Do you smoke? No ___ Yes ___ How much: _____

Do you drink alcohol? No ___ Yes ___ Frequency: _____

Do you use drugs? No ___ Yes ___ Frequency: _____

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HIPAA CONSENT
Patient Record of Disclosures

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the Individual's office instead of their home.

I wish to be contacted in the following manner (check all that apply)

_____ ***Home Telephone***
___ OK to leave message with details
___ Leave message with call-back number only

_____ ***Work Telephone***
___ OK to leave message with details
___ Leave message with call-back number only

_____ ***Cell Telephone***
___ Ok to leave message with details
___ Leave message with call-back number only

_____ ***Written Communication***
___ OK to mail to my home address
___ OK to mail to my work & fax

_____ ***Email Communication***
___ Ok to send e-mail

I acknowledge that I have read a copy or declined the opportunity to read the Notice of Privacy Practices for HIPAA. By signing this form, I also allow any medication data to be pulled off the national data base.

Patient Name (Please Print): _____

Signature: _____ Date: _____

The privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute and adequate record. I understand my doctor will request the medical information from pharmacies and I may deny they do this.
Note: Uses and disclosures for Treatment Records, Payment Information and Healthcare Operations may be permitted without prior consent in an emergency.

SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS INSURANCE INFORMATION, FINANCIAL AGREEMENT

Patient's Name:

_____

MEDICARE: I request that payment of authorized Medicare benefits be made on my behalf to MacQuaid Eye Institute, for services furnished to me. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) and its agents any information needed to determine these benefits payable for services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated as a Secondary Insurance (in Item 9 of the HCFA 1500 claim form or electronically transmitted), my signature authorizes releasing the information to the insurer shown. MacQuaid Eye Institute accepts the charge determination of Medicare and I am responsible for coinsurance, deductibles, and non-covered services.

OTHER INSURANCE: I request that payment of authorized benefits be made on my behalf to MacQuaid Eye Institute, for services furnished to me. I authorize any holder of medical information about me to release to my insurance company any information needed to determine benefits payable for services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim.

FINANCIAL AGREEMENT: I agree that in return for the services provided by MacQuaid Eye Institute, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to the practice. If my account is sent to collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court. Most insurance companies require you to pay co-payments and deductibles. These are due, if known, at the time of service as well as any non-covered services. It is understood that I am primarily responsible for the payment of any services not covered by my insurance. If I do not pay my copay at the time of service, I understand there will be additional fee assessed.

FAILURE TO KEEP APPOINTMENT: We reserve the right to charge a no-show fee in the event you cancel your appointment with less than 24-hour notice.

_____ _____

Signature of Patient or Authorized Representative ***Date***

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INFORMED CONSENT FOR TELEMEDICINE

Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following: · Patient medical records · Medical images · Live two-way audio and video · Output data from medical devices and sound and video files

Expected Benefits: · Improved access to medical care by enabling a patient to remain in his/her ophthalmologist's office (or at a remote site) while the physician obtains test results and consults from healthcare practitioners at distant/other sites. · More efficient medical evaluation and management. · Obtaining expertise of a distant specialist.

I understand that during the telemedicine consultation my medical history, examinations and lab results will be discussed with my healthcare provider.

- Video, audio and/or photo recording may be taken of me during the visit. Please note, not all telecommunications are recorded and stored.

I understand that all existing laws regarding my access to my medical records still apply to telemedicine communications. Additionally, I understand dissemination of any identifiable images or information for this telemedicine interaction to researchers or other entities is prohibited without my consent. HIPAA still applies for all telemedicine communications.

I understand that I may withdraw my consent to the telemedicine consultation at any time without it affecting my right to future care or treatment.

I understand the potential risks with telemedicine, as there are with any medical treatment. In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician. There may be delays in medical evaluation due to failures or deficiencies of equipment. In very rare instances, security protocols could fail, causing a breach of privacy of my medical information.

I understand that by signing this form that I am consenting to receive health services via telemedicine.

Patient/Guardian/Agent Signature Date