PATIENT INFORMATION

GLAUCOMA CONSULTANTS

Name (Last, First, MI)			
Sex	Date of Birth	Social Security#	
Home Phone ( )		Marital Status	
Address	City	State	Zip
Occupation		Employer	
Work Address			
Work Phone		**CELL PHONE**	
E-Mail Address			

Referring Physician		Phone ( )
Referring Physician Address		
Medical Doctor		Phone ( )
Medical Doctor Address		
Emergency Name	Phone ( )	Relationship

Guarantor Information (Complete is other than patient)

Guarantor Name	Phone ( )
Guarantor Address	
Guarantor Social Security #	Relationship to Patient
Guarantor Employer	Guarantor Date of Birth
Work Address	Work Phone ( )

Primary Insurance

Ins. Name	Phone( )
Ins. Co. Address	
Name of Policy Holder	Relationship to Patient
Policy #	Policy Holder Date of Birth
Employer	Group Name
Group Number	Effective Date

Secondary Insurance

Ins. Name	Phone( )
Ins. Co. Address	
Name of Policy Holder	Relationship to Patient
Policy #	Policy Holder Date of Birth
Employer	Group Name
Group Number	Effective Date

By signing I attest the information is true and correct. I agree to be financially responsible for any services provided by Glaucoma Consultants if: insurance information is not correct, not covered by my plan, applied to co insurance or deductibles, or the required authorizations or referrals have not been obtained.

I authorize payment of insurance benefits to Glaucoma Consultants for services rendered during my entire course of treatment and care in accordance with the coverage provisions of my insurance contract.

I authorize the holder of my medical information to release to my insurance carrier, any information needed to determine these benefits. I permit this authorization to be used in place of original signature. The authorization, unless revoked by me or my guarantor in writing, will remain in my medical record for life.

Signature:_____ Date:_____

MEDICAL HISTORY AND REVIEW OF SYSTEMS **GLAUCOMA CONSULTANTS**

Name_____**Sex** ____**Age** ____**Date**_____

Medical Doctor _____ **Medical Doctor Phone#** _____

Past Medical History	Yes	No	Explanation	Review of Systems	Yes	No	Explanation
Arthritis				Pregnant			
Asthma/Emphysema				Blood in Bowels			
Bleeding Problems				Breathing Problems			
Cancer				Chest Pain			
Diabetes				Depression/Anxiety			
Heart Attack				Dizziness			
Heart Disease				Fevers			
High Blood Pressure				Joint Pain			
High Cholesterol				Liver Disease			
Irregular Heartbeat				Numbness/Tingling			
Kidney Disease				Skin Rash or Tumor			
Migraine Headaches				Sleeping Difficulties			
Psychiatric Problems				Swollen Glands			
Seizures				Ulcer			
Stroke				Urinary Problems			
Thyroid Disease				Weight Loss			
Deafness				Hearing loss			
Abdominal pain				Vomiting/Diarrhea			
Nose/Throat				Sinus problems/sore throat			
Other				Other			

Surgeries (Type, When Performed)	**Medications and Dosage**
Allergies to Medication (Name, Reaction)	

Past Ocular History	Yes	No	Family History	Yes	No
Glaucoma			Glaucoma		
Cataracts			Loss of Vision		
Crossed or lazy eyes			Macular Degeneration		
Eye Injury			Diabetes		
Retinal Disease			**Social History**	----------	
Blindness			Do you smoke?		
Reading Glasses			# cigs/day, how many years? If quit, when?		
Distance Glasses			Do you drink alcohol?		
Bifocals			How much/often?		
Contact Lenses			Do you take street drugs?		
Laser surgery of eye			Do you live alone?		
Eye Surgery			Does your vision hamper your lifestyle?		

Glaucoma Consultants

Gail F. Schwartz, M.D. **Raya Armaly, M.D.** **Anjana P. Jindal, M.D.**

Telephone (410) 825-9225

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Ophthalmology • Practice Limited to Glaucoma
www.glaucomaconsultantsmd.com

Fax (410) 825-9229

Authorization to Release Medical Information

I authorize Glaucoma Consultants to release Medical/Protected information to:

_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship

_____ _____

Signature **Date**

_____

Relationship

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you can gain access to this information. Please review it carefully.

Protected health information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services.

Our practice is required to follow specific rules on maintaining the confidentiality of your PHI, using your information, and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules and use and disclose your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

Your Rights Under The Privacy Rule

Following is a statement of your rights, under the Privacy Rule, in reference to your PHI. Please feel free to discuss any questions with our staff.

You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices - We are required to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment. The Notice will also be posted in a conspicuous location within the practice, and if such is maintained by the practice, on it's web site.

You have the right to authorize other use and disclosure - This means you have the right to authorize any use or disclosure of PHI that is not specified within this notice. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or our practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to request an alternative means of confidential communication – This means you have the right to ask us to contact you about medical matters using an alternative method (i.e., email, telephone), and to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, using a form provided by our practice, how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.

You have the right to inspect and copy your PHI - This means you may inspect, and obtain a copy of your complete health record. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable fee for paper or electronic copies as established by professional, state, or federal guidelines.

You have the right to request a restriction of your PHI - This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

You may have the right to request an amendment to your protected health information - This means you may request an amendment of your PHI for as long as we maintain this information. In certain cases, we may deny your request for an amendment.

You have the right to request a disclosure accountability - This means that you may request a listing of disclosures that we have made, of your PHI, to entities or persons outside of our office.

You have the right to receive a privacy breach notice - You have the right to receive written notification if the practice discovers a breach of your unsecured PHI, and determines through a risk assessment that notification is required.

If you have questions regarding your privacy rights, please feel free to contact our Privacy Manager. Contact information is provided at right, under Privacy Complaints.

How We May Use or Disclose Protected Health Information

Following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.

Treatment - We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other Healthcare Providers who may be involved in your care and treatment.

Special Notices - We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests and to provide information that describes or recommends treatment alternatives regarding your care. Also, we may contact you to provide information about health-related benefits and services offered by our office, for fund-raising activities, or with respect to a group health plan, to disclose information to the health plan sponsor. You will have the right to opt out of such special notices, and each such notice will include instructions for opting out.

Payment - Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you such as, making a determination of eligibility or coverage for insurance benefits.

Healthcare Operations - We may use or disclose, as needed, your PHI in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, auditing functions and patient safety activities.

Health Information Organization - The practice may elect to use a health information organization, or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

To Others Involved in Your Healthcare - Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person, that you identify, your PHI that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your general condition or death. If you are not present or able to agree or object to the use or disclosure of the PHI, then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed.

Other Permitted and Required Uses and Disclosures - We are also permitted to use or disclose your PHI without your written authorization for the following purposes: as required by law; for public health activities; health oversight activities; in cases of abuse or neglect; to comply with Food and Drug Administration requirements; research purposes; legal proceedings; law enforcement purposes; coroners; funeral directors; organ donation; criminal activity; military activity; national security; worker's compensation; when an inmate in a correctional facility; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

Privacy Complaints

You have the right to complain to us, or directly to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying the Privacy Manager at:

_____

We will not retaliate against you for filing a complaint.

Effective Date 7/2014

Publication Date 7/2014

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NOTICE OF PRIVACY PRACTICES

By law, we are required to provide you with our Notice of Privacy Practices.
THIS NOTICE DESCRIBES HOW MEDICAL/PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

As a patient, you have the following rights:

1) The right to inspect and copy your information;
2) The right to request corrections to your information;
3) The right to request that your information be restricted;
4) The right to request confidential communications;
5) The right to a report of your disclosures of your information;
6) The right to a paper copy of this notice.

We want to assure you that your medical/protected health information is secure with us. This notice contains information about how we will insure that your information remains private.

If you have any questions about this Notice, the name and phone number of our contact person is:

Lynn Blais
Practice Administrator
410-825-9225

Acknowledgement of Notice of Privacy Practices

"I hereby acknowledge that I have received a copy of Glaucoma Consultants NOTICE OF PRIVACY PRACTICES. I understand that if I have questions or complaints regarding my privacy rights that I may contact the person listed. I understand that the Glaucoma Consultants will offer me updates to this NOTICE OF PRIVACY PRACTICES should it be amended, modified, or changed in any way."

_____ _____

Please Print Relationship to Patient

_____ _____

Patient or Representative Signature Date

□Patient refused to sign □Patient unable to sign because

_____