Glaucoma Consultants

Gail F. Schwartz, M.D.
Raya Armaly, M.D.

Anjana P. Jindal, M.D.
Katherine A. Fallano, M.D.

Telephone (410) 825-9225

GBMC Physicians Pavillion East
6565 N. Charles Street, Suite 302
Baltimore, MD 21204

Fax (410) 825-9229

Ophthalmology • Practice Limited to Glaucoma
www.glaucomaconsultantsmd.com

** ***If you use a GPS for driving directions, Please read the top of the 2nd page carefully.*****

Hello_____

To save time on your initial visit, please fill out the forms attached. Please include your primary care physician's phone number as well as their address, and any other physicians that you wish to receive a report of your office visit with us. Please remember to sign and date where indicated.

Be sure to bring all insurance cards as well as a Photo ID, so that we can copy them.

For your first office visit with us you will likely be dilated, so if you need have someone with you, please make those arrangements. The average length of your visit will be 2 hours.

PLEASE MAKE SURE THAT IF YOUR INSURANCE COMPANY REQUIRES A REFERRAL THAT YOU HAVE RECEIVED ONE FROM YOUR PRIMARY CARE PHYSICIAN.(Not your eye doctor.) It is your responsibility to have a referral at the time of your visit.

We look forward to meeting you.

Your appointment is on _____at_____

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DIRECTIONS TO GBMC

For GPS ⟹ If you plan to use a GPS for directions you must input the following address*6701 N. Charles Street, Towson MD 21204

Once in the GBMC Campus get your parking ticket then bare to the right, follow any signs for Iris Park once you bare right and keep going straight you will need to go straight into the Iris Parking Garage. Once on the 1st floor of Iris Garage Walk across the street into the East Pavilion. Then take the elevator on your left to the 3rd floor. We are Suite # 302.

Greater Baltimore Medical Center (GBMC), Is located on N. Charles St. in Towson, just north of the Baltimore City line, between Bellona Ave. & Towsontown Blvd. GBMC is only 15 mins from Baltimore Inner Harbor.

FROM: I-695 Baltimore Beltway Turn right onto exit 25, Charles Street. Go South for 1.5 miles. The very next traffic light AFTER Towsontown Blvd turn left onto the GBMC Campus.

FROM: Pennsylvania GBMC is approximately 25 minutes from the Pennsylvania Border. Take I-83 south until it splits left to i-695 East towards Towson. Take I-695 & immediately turn right onto exit 25 (Charles Street). Proceed 1.5 miles, turn left at the 1st traffic light AFTER Towsontown Blvd.

From: Delaware Take I-95 South to I-695 West towards Towson. Follow I-695 to exit 25 (Charles Street). Turn left from exit ramp, & follow the small traffic circle onto Charles Street, go south for 1.5 miles, turn left at the 1st traffic light AFTER Towsontown Blvd.

From: Washington D.C./BWI Airport Take I-295 North to I-695 North towards Towson. Follow I-695 to exit 25 (Charles Street), proceed 1.5 miles South on Charles Street, turn left at the 1st traffic light AFTER Towsontown Blvd.

FROM: Downtown Baltimore Take I-83 North to Northern Pkwy Exit. Turn right onto Northern Pkwy. Follow to N. Charles Street, turn left, & proceed North on Charles Street for 2.2 miles. Turn Right onto GBMC campus.

FROM: Western Maryland Take I-70 East to I-695 North towards Towson. Follow I-695 to exit 25 (Charles Street), go South for 1.5 miles, turn left at the 1st traffic light AFTER Towsontown Blvd.

FROM: Eastern Shore Take the Bay Bridge to I-97 North. Follow I-695. Take to I-695 North to exit 25(Charles Street), go South for 1.5 miles, turn left at the 1st traffic light AFTER Towsontown Blvd.

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?		

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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

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Financial Policy

Thank you for choosing Glaucoma Consultants. All patients must complete our Medical History Form and our Financial Policy Form before seeing our physicians. Our office policy requires that we scan your insurance card(s) every visit. You are responsible for providing us with your insurance information, a form of identification and keeping this information current. If we experience a claim denial because your information is outdated or incorrect, any balance due becomes your responsibility.

If your insurance company states you have co-pay, this copay is due and payable at the time of your visit.

We accept Cash, Checks, Visa, MasterCard, Discover or American Express.

Medicare
All of our physicians participate with Medicare and accept assignment. If your insurance is Medicare, you will be responsible for the 20% of what Medicare allows. We will bill your secondary insurance company if you supply us with the information. If Medicare is your only insurance, or your secondary insurance company does not remit payment within 60 days, the balance will become your responsibility.

Commercial Insurance Companies (for patients without Medicare Insurance)
As a courtesy to you, we will submit claims to no more than two commercial insurance companies provided we have the name and complete mails address. If payment is not received from your insurance provider within 30 days, as required by Maryland law, the balance will become your responsibility.

HMO/PPO Insurance
All of our physician participate with various HMO/PPO insurance companies. If you need clarification as to whether we participate with your HMO/PPO, please call our office. It is your responsibility to obtain all referrals and authorizations for office visits prior to your appointment. If a valid referral or authorization is not available, you will need to sign a waiver making you responsible for the charges or we will reschedule your appointment.

Patients with no Insurance Coverage
If there is no active insurance coverage for the service date, you will be required to pay 50% of the charge for that visit at the time the services are rendered. The remaining 50% will be billed to you and is payable within 30 days of receipt of the bill, unless other arrangements are made with our billing department.

Turn Page Over

Medical Assistance of Maryland
All of our physicians participate with Maryland Medicaid. On the day of your visit, we will call to verify that your coverage is active. If coverage is active, we will bill Medicaid for you. If not coverage is active, the guidelines for patients without insurance, will apply.

Medical Assistance of other states, outside of Maryland
Because Medicaid coverage and reimbursement is controlled separately by each state, we will not be able to accept Medicaid from states other than Maryland. Please refer to the guidelines above for patients with no insurance coverage.

Payment of Balances
In the event that your insurance company sends payment for services directly to you, it is your responsibility to forward the payment along with a copy of the explanation of benefits to our office.

Past Due Balances
If you come for an appointment and there is a balance on your account and the balance is over 60 days or has been forwarded to a collection agency, you will be required to pay this before you are seen unless other arrangements have been made with our billing department.

Please let us know if there are questions.

Acceptance and Authorization to bill Insurance

I have read, understand, and agree to this Financial Policy. By my signature below, I request that payment of authorized benefits be made on my behalf to Glaucoma Consultants for services furnished to me by the provider. I authorize any holder of medical information about me to release to my insurance company or any third-party payer any information needed to determine these benefits or the benefits payable for related services. I also understand and acknowledge that I am personally responsible to pay Glaucoma Consultants in full for services that my health insurer will not cover due to non-payment of health insurance premiums.

_____

Signature of Patient Date

_____

Signature of Responsible Party (if patient unable to sign) Date

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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

_____

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 _____ Publication Date _____