Health Insurance Portability and Accountability Act (HIPAA) Compliance Patient Consent Form

Our Notice of Privacy Practices, required by HIPAA, provides information about how we may use or disclose protected health information. The notice contains a patient’s rights section describing your rights under the law. Your signature confirms that you have had the opportunity to review our notice before signing this consent. The terms of the notice may change; if so, you will be notified at your next visit to update your signature/date.

By signing this form, I understand that:
  o Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
  o The practice reserves the right to change the privacy policy as allowed by law.
  o The patient has the right to request a restriction on the use of the information, but the practice does not have to agree to those restrictions.
  o The patient has the right to revoke this consent in writing at any time.
  o The practice may require this form to be fully executed in order to offer treatment.

My signature confirms that I have read this information and I understand my rights under HIPAA.

_________________________________________________  _________________________________
Patient Name / Guardian      Date
_________________________________________________
Patient / Guardian Signature

Health Insurance Portability and Accountability Act (HIPAA) - Email Consent

Please be aware that although the information stored on our computers is encrypted, most popular email services do not utilize encrypted email. This means that when we send you an email, or you send us an email, the information is not encrypted. Without encryption, a third party may be able to access the information and read it. Once an email is received by you, it can be accessed by outside parties and read.


The guidelines state that if a patient has been made aware of the risks of unencrypted email, and that the same patient provides consent to receive health information via email, then a health entity may send that patient personal medical information via unencrypted email.

I understand the risks of unencrypted email and do hereby give permission to Wills Eye, to include the specialty services, to send me personal health information via unencrypted email.

I have read, understand and will comply with the information contained within this email policy.

___________________________________________________  ______________________________
Patient Name / Guardian / Agent     Date
___________________________________________________   ______________________________
Patient / Guardian / Agent Signature     Relationship
AUTHORIZATION FOR TREATMENT
The undersigned hereby consents to any medical treatment or hospital services rendered the patient under the general and special instructions of the attending physician and other assigned physicians or paraprofessionals providing care to the patient. I also acknowledge that no guarantee or warranty has been made by said physicians of Wills Eye as to the result of any treatment or procedure which may be given or performed. For the purposes of advancing medical education, I consent to the presence of observers to the patient’s treatment.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION
Wills Eye is hereby authorized to release all or any part of the medical record including information concerning substance abuse, mental illness or HIV status of the patient named on this form for the purposes of treatment, payment, or operations. I authorize the use of my medical information for teaching purposes.

I certify that the information given by me in applying for payment under title XVIII of the Social Security Administration or its intermediaries or carriers or other third party payers, any information needed for payment of this or a related claim.

CONSENT TO PHOTOGRAPHY AND RESEARCH
I consent to having photographs and recordings of my image and voice, and I agree that upon creation, those images and recordings are owned by Wills Eye Hospital. I understand that I have the right to request that recording or filming stop at any time. I agree to release Wills Eye Hospital and its affiliates for the use of these images and recordings. Wills Eye Hospital is also a teaching and research institution. I understand that my medical information, including specimens, may be used in future educational and research activities. Clinical studies at Wills Eye Hospital go through a special process required by law that reviews patient welfare and privacy.

AUTHORIZATION FOR PAYMENT
I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to Wills Eye and authorize Wills Eye to submit a claim to Medicare or other third party payer for payment.

FINANCIAL AGREEMENT
The undersigned agrees, whether he signs as a patient or the agent of a patient that in consideration of the service to be rendered to the patient, to be responsible for prompt payment of Wills Eye fees in accord with the regular rates and terms. I understand this agreement includes any amounts not covered by the patient’s insurance.

The undersigned certifies that he/she has read the foregoing and is the patient, or is duly authorized as the patient’s agent to execute the above and accept its terms.

I certify that the information shown on this form is true, correct, and accurate. I understand that payment and satisfaction of this claim may be from Federal and State funds and that any false claims, statements, or documents or concealment of material facts may be prosecuted under applicable federal and state laws.

___________________________________________________  ______________________________
Patient Name / Guardian / Agent     Date

___________________________________________________   ______________________________
Patient / Guardian / Agent Signature     Relationship
Patient Authorization for Personal Representative

Patient Name: _______________________________________________________________________

Date of Birth: _______________________________________________________________________

I authorize Wills Eye, to disclose or provide my protected health information to the following individual who is authorized to act as my personal representative for the purposes of receiving all protected health information about myself. As my designated personal representative, he/she may exercise my right to inspect, copy, and request amendments to my protected health information. He/she may also consent or authorize the use or disclosure of my protected health information:

Name of Personal Representative and Phone Number

Address

City, State, Zip

Description of information to be disclosed: I authorize the practice to disclose all of my protected health information to my designated personal representative.

Expiration or termination of authorization: This authorization will remain in effect until terminated by you, your personal representative or another individual(s) of legal entity authorized to do so by court order or law.

Right to revoke or terminate: As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager. This can be done in-person or by mailing a request to:

Privacy Officer
Wills Eye Physicians
840 Walnut Street
Philadelphia, PA 19107

Patient Name / Guardian / Agent

Date

Patient / Guardian / Agent Signature

Relationship
Last Name ________________________   First Name ________________________ Middle _______________
SSN ______________________________  DOB _____________________________ Birth Sex:    Male / Female
Street _____________________________________________________   Apt# _______________
City ______________________________   State ____________________ Zip ______________
Race: _______________________________
Primary Language: ____________________
Latino / Hispanic:  Yes / No
Marital Status:  Single / Married / Divorced / Widowed
Student Status:  FT / PT / N/A

CONTACT INFORMATION
Home Phone: __________________________________
Day Phone: ____________________________________
Emergency Phone: ______________________________
Email Address: _________________________________

MEDICAL INSURANCE

Insurance Company: _____________________________    Effective Date: _____________________________
Insured ID: ________________________________  Insured Name (if not patient): _____________________________
Insured Date of Birth: _____________________________  Insured Relationship to patient:  Spouse / Parent
Group #: ________________________________  Group Name: ______________________________________
Specialist Copay: _____________________________  Referral Required:  yes / no
Patient Name________________________________________      Date of Birth _______________________________
PATIENT MEDICAL HISTORY QUESTIONNAIRE

*Please complete these forms as thoroughly as possible*

Reason for consultation / visit: ________________________________________________________________

Do you wear glasses:  yes / no       Do you wear contact lenses:  yes / no

**ALLERGIES**

<table>
<thead>
<tr>
<th>Allergen</th>
<th>Describe Reaction (Rash, etc.)</th>
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**OCULAR (EYE) HISTORY**

<table>
<thead>
<tr>
<th>Disease/Problem/Surgery</th>
<th>Date Diagnosed</th>
<th>Treatment Received</th>
<th>By Whom</th>
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ANY OCULAR (EYE) SURGERIES NOT LISTED ABOVE?  yes / no

If yes, please explain ____________________________________________________________

**MEDICAL HISTORY**

Do you have environmental or food allergies?  yes / no ________________________________

Do you have chest pressure, discomfort, irregular heartbeat or palpitations?  yes / no ______________________

Do you suffer from fatigue, fever, or night sweats?  yes / no ____________________________

Do you have an intolerance to heat or cold?  yes / no _________________________________

Patient Name________________________________________      Date of Birth _______________________________
Do you suffer from hearing loss? yes / no _______________________________________________________
Do you suffer from constipation, diarrhea, or vomiting? yes / no _____________________________________
Do you suffer from painful urination or blood in your urine? yes / no _________________________________
Do you bruise easily? yes / no _________________________________________________________________
Do you have any rashes or skin irritations? yes / no _______________________________________________
Do you suffer from joint swelling, arthritis, or muscle weakness? yes / no ____________________________
Do you suffer with headaches, dizziness, or gait disturbances? yes / no ______________________________
Are you suffering from any emotional changes? yes / no ___________________________________________
Do you suffer with coughing or wheezing? yes / no ______________________________________________
Other medical conditions ________________________________________________________________

OPHTHALMIC (EYE) MEDICATIONS

<table>
<thead>
<tr>
<th>Medication</th>
<th>Strength</th>
<th>Dosage</th>
<th>Which Eye</th>
<th>Condition Treated</th>
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ADDITIONAL MEDICATIONS  
(For example: Lisinopril, 20mg, once a day, for hypertension)

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<tr>
<th>Medication</th>
<th>Strength</th>
<th>Dosage / Frequency</th>
<th>Condition Treated</th>
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Pharmacy Name: __________________________________________________________
Pharmacy Address: __________________________________ Fax: ______________________

Patient Name________________________________________      Date of Birth _______________________________
Are you diabetic:   Yes (please circle)   Type 1 diabetes or Type 2 diabetes

Insulin dependent: yes / no    If yes, for how long: ________________

Recent Blood Sugar ____________________ Date ________________

A1C _______________________%________  Date ________________

No - I am not diabetic

FAMILY HISTORY

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<th>Family Member</th>
<th>Diagnosis</th>
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SOCIAL HISTORY

Do you smoke: yes / no / previously    If yes, how long ____________________________

Do you drink alcohol: yes / no    If yes, how much / frequency ______________________

Do you drink caffeine: yes / no    If yes, how much ______________________________

Do you use recreational drugs: yes / no / previously

Have you had any falls in the last year: yes / no    If yes, number of falls ________________

If yes, did any of the falls result in injury: yes / no

___________________________________________________  ______________________________
Patient Name / Guardian / Agent     Date

___________________________________________________   ______________________________
Patient / Guardian / Agent Signature     Relationship