Last Name First Name Middle

DOB Birth Sex: Male Marital Status: Single

Street Apt#

City State Zip

Race: Primary Language: Latino / Hispanic: No

CONTACT INFORMATION

Home Phone: Day Phone: Emergency Phone:

Email Address:

MEDICAL INSURANCE

Insurance Company: Insured ID:

Insured Name (if not patient): Insured Date of Birth:

Insured Relationship to patient: Group #:

Group Name: Specialist Copay: No Referral Required: No

PHARMACY

Name: Address:

City: State: Zip: Fax:

PRIMARY CARE DOCTOR

Name: Address:

City: State: Zip: Fax:

REFERRING DOCTOR

Name: Address:

City: State: Zip: Fax:

OTHER DOCTOR

Name: Address:

City: State: Zip: Fax:

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:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- 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.
- The patient has the right to revoke this consent in writing at any time.
- 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 / Agent Date

Patient / Guardian / Agent Signature Relationship

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 federal government has provided guidance on email and HIPAA on the U.S. Department of Health and Human Services website: http://www.gpo.gov/fdsys/pkg/FR-2013-01-25/pdf/2013-01073.pdf

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

Patient Name Date of Birth

PATIENT MEDICAL HISTORY QUESTIONAIRE

Please complete these forms as thoroughly as possible

Reason for consultation / visit:

Do you wear glasses: No

Do you wear contact lenses: No

ALLERGIES NONE ☐

Allergen	Describe Reaction (Rash, etc.)

OCULAR (EYE) HISTORY NONE ☐

Disease/Problem/Surgery	Date Diagnosed	Treatment Received	By Whom

ANY OCULAR (EYE) SURGERIES NOT LISTED ABOVE?

If yes, please explain

MEDICAL HISTORY

Do you have environmental or food allergies? No

Do you have chest pressure, discomfort, irregular heartbeat or palpitations? No

Do you suffer from fatigue, fever, or night sweats? No

Do you have an intolerance to heat or cold? No

Patient Name Date of Birth

Do you suffer from hearing loss? No

Do you suffer from constipation, diarrhea, or vomiting? No

Do you suffer from painful urination or blood in your urine? No

Do you bruise easily? No

Do you have any rashes or skin irritations? No

Do you suffer from joint swelling, arthritis, or muscle weakness? No

Do you suffer with headaches, dizziness, or gait disturbances? No

Are you suffering from any emotional changes? No

Do you suffer with coughing or wheezing? No

Other medical conditions

OPHTHALMIC (EYE) MEDICATIONS NONE ☐

Medication	Strength	Dosage	Which Eye	Condition Treated

ADDITIONAL MEDICATIONS *(For example: Lisinopril, 20mg, once a day, for hypertension)* NONE ☐

Medication	Strength	Dosage / Frequency	Condition Treated

Patient Name Date of Birth

Are you diabetic: No

Insulin dependent: No If yes, for how long:

Recent Blood Sugar Date

A1C % Date

FAMILY HISTORY

Family Member	Diagnosis

SOCIAL HISTORY

Do you smoke: No If yes, how long

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

Do you drink caffeine: No If yes, how much

Do you use recreational drugs: No

Have you had any falls in the last year: No If yes, number of falls

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

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