Please use this form if someone other than the parents or legal guardian are bringing your minor child for an exam.

Fax: 410-757-0632 Email: ckosman@annapoliseyecare.com

Date:_____ Patient Name: _____

Parents Name: _____

Best number to contact you during the day:

_____

I _____ give permission for

(parents Name)

_____, to bring my child, _____

(Name and relationship) (Child's name)

to Ophthalmology Associates of Greater Annapolis to be examined and treated by Dr. John M. Avallone and/or Dr. Jared E. Duncan for their eye care needs.

Parents Signature: _____

This permission expires: _____

OPHTHALMOLOGY
ASSOCIATES OF GREATER ANNAPOLIS

Patient Demographics

Last Name: _____ First Name: _____ MI: ___ DOB: _____ Sex: (M / F)
Address: _____ City: _____ State: _____ Zip: _____
Cell Phone: _____ Home Phone: _____ Work Phone: _____
E-Mail: _____ Driver's License #: _____ SSN: _____

Race: _____ **Ethnicity**: _____ **Preferred Language**: _____

Spouse/Parent/Guardian (circle one): _____ SSN: _____
Cell Phone: _____ Home Phone: _____ Work Phone: _____

Emergency Contact Name: _____
Cell Phone: _____ Home Phone: _____ Work Phone: _____

Primary Care Physician: _____ Phone: _____ Fax: _____
Practice Name: _____
Address: _____ City: _____ State: _____ Zip: _____

Referring Physician_____ Phone: _____ Fax: _____
Practice Name: _____
Address: _____ City: _____ State: _____ Zip: _____

Employer_____ Phone: _____ Fax: _____
Address: _____ City: _____ State: _____ Zip: _____

Insurance Information:

Please present all insurance cards to the receptionist to insure proper insurance benefit processing

Primary Insurance Co: _____ Insured Name: _____
Insured DOB: _____ Insured SSN: _____ Relationship to Patient: _____
Secondary Insurance Co: _____ Insured Name: _____
Insured DOB: _____ Insured SSN: _____ Relationship to Patient: _____

Financial Disclosure: We want you to know that Steven H. Sherman, M.D., John M. Avallone, M.D. and August C. Pasquale III, M.D. own a business interest in the Surgical Center of Greater Annapolis.

Authorization to Disclose Medical or Financial Information

I authorize Ophthalmology Associates of Greater Annapolis (OAGA) to disclose medical or financial information to:

_____ _____
Authorized Individual's Name Phone Number

_____ _____
Authorized Individual's Name Phone Number

To the best of my knowledge, the above information is correct. I may notify this office at any time in writing to rescind or change any of the above information.

_____ _____
Patient/Parent/Guardian Signature Date

Financial Acknowledgements

Please initial by each paragraph below

- **Release of Information**: I authorize OAGA to release medical information on my behalf to my insurance company to process claims for services rendered. Under Federal and State HIPAA compliance regulations, this includes any information provided by you or your legal guardian. This release may include information regarding your health, family or social history, alcohol or drug use, psychiatric illness, communicable disease or HIV. If you do not want your record released, you must submit this in writing. If we are unable to submit claims to your insurance, you will be fully responsible for bills incurred.

- **Insurance Contracts**: OAGA participates with multiple insurance carriers. We will submit all claims on your behalf as required under our contracts. If we do not have a contract with your insurance carrier, we will provide you with a detailed receipt for you to submit. *We DO NOT participate with Davis Vision, Blue Vision, VSP, Cigna HMO or State Medical Assistance.*

- **Non-Covered Services**: Your insurance does not cover certain services and/or products. Payment is due for these services and/or products at the time of service. Examples of such products include dry eye products, vitamins, eye patches, eyeglasses, sunglasses and accessories.

- **Refraction**: A refraction is a test to determine your need for glasses. There is a separate charge independent of your eye exam for a refraction and glasses prescription. The eye exam checks the health of your eyes. *Medicare, Carefirst and most insurance carriers DO NOT cover this fee*. The fee is due at the time of service in addition to your co-pay and/or deductible.

- **Self-pay accounts, Workers Compensation, Motor Vehicle Accidents and visits without required HMO Referrals**: If you do not have insurance or you do not provide us with complete and accurate insurance to bill for services rendered, then you are held responsible for all fees incurred. HMO Referrals are due at the time of service. You assume full responsibility for services rendered by not providing your required referral.

- **Financial Liability for services rendered**: I understand that I am fully responsible for all services provided to me or my legal dependent that are not covered by my health insurance plan, vision plan, Medicare or Maryland Medicaid. *All co-pays, non-covered services and refraction fees are due at the time of services*. All billings are due upon receipt. Balances not paid within 90 days are reviewed for collections. Accounts sent to collections will incur additional collections fees, interest and legal fees if assigned to an attorney or collection agency. Please note, unpaid co-pays and/or deductibles are a breach of the contract you have with your insurance carrier.

- **Appointments** missed or not cancelled within 24 hours before the appointment time will result in a $25 fee.

By signing below, I acknowledge all of the above information as it has been presented to me.

_____ _____

Patient/Parent/Guardian Signature Date

ePrescribe is a way for doctors to send electronically an accurate, legible prescription to your pharmacy. Your medication history is a list of your prescriptions from your doctors through a variety of sources including pharmacies and health insurers. This medication history is accessible utilizing electronic information exchanges, is part of your medical record and can provide valuable information for your physicians by helping to identify potentially adverse drug interactions, allergies, duplications or redundancies.
I understand that my medication history is protected health information and I may revoke consent in writing at any time. I hereby provide informed consent to enroll in this ePrescribe program.

_____ _____

Pharmacy Name Pharmacy Location

_____ _____

Patient/Parent/Guardian Signature Date