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 #: _____

**Race**: _____ **Ethnicity**: _____

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

**Primary Care/Referring Physician**: _____Phone: _____
Practice Name: _____Fax: _____
Address: _____City: _____State: _____ Zip: _____

## Insurance Information

**Please present all insurance cards to the receptionist to ensure proper insurance benefit processing.**

**Primary Insurance Company**: _____
Policy holder's (insured) Name: _____
Policy holder's (above) DOB: _____ Relationship to Patient: Spouse/Parent/Child/Other_____

**Secondary Insurance Company**: _____
Policy holder's (insured) Name: _____
Policy holder's (above) DOB: _____ Relationship to Patient: Spouse/Parent/Child/Other_____

**Employer**_____ Phone: _____ Fax: _____
Address: _____City: _____State: _____ Zip: _____

## 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

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

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## 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 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.

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

By signing below, I certify the information provided is true to the best of my knowledge and I completely understand the financial acknowledgements.

_____ _____

Patient/Parent/Guardian Signature Date