Dear Patient,

We would like to thank you for choosing us for your medical eye care needs. We are pleased to have you as a patient and look forward to providing you only the best possible care. In order to serve you best please be prepared with the following:

- Insurance card(s)
- Photo ID
- List of current medications
- Co-payments, co-insurances as required by your insurance
- Glasses if you wear them
- If you wear contact lenses, please wear them for an hour prior to appointment and bring your glasses with you.

Our office is open to serve you on Monday, Wednesday, Thursday and Friday from 7am-5pm, and Tuesday from 7am-4pm. Please notify the office at least 24 hours prior if you are unable to keep the scheduled appointment.

Again, thank you for allowing us to care for you. We look forward to working with you.

Sincerely,

Philip J. McGann, M.D. and the staff of Western Maryland Eye Center
Western Maryland Eye Center, Philip J. McGann, M.D., PA

Written Acknowledgement

I am a patient of Philip J. McGann, M.D. I hereby acknowledge receipt of Western Maryland Eye Center's Notice of Privacy Practices.

Name: __________________ Signature: __________________ Date: ____________

-OR-

I am a parent or legal guardian of __________________ [Patient name]. I hereby acknowledge receipt of Western Maryland Eye Center's Notice of Privacy Practices with respect to the patient.

Name: __________________ Signature: __________________ Date: ____________

Relationship to patient: ___ Parent ___ Legal Guardian

Signature: __________________ Date: ____________

Patient Communication

A. Family and Friends. It is the policy of Western Maryland Eye Center not to release confidential medical information regarding your treatment to family members or friends, except for (i) parent/legal guardian, (ii) other persons authorized by the patient, (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that that person is entitled to receive information regarding your treatment), (iv) in emergency situations, or (v) other as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you anticipate that you will need or want your medical information to be provided to family members, friends, or caretakers/babysitters, please indicate that below, so that we may best serve you. If you do not want any of your medical information provided to a family member please check the line next to “NO” response. By signing below, you authorize the following people to receive information regarding your treatment or care. If you wish to add names later on, please confirm in writing, or call the staff.

Spouse: __________________ yes ___ No
Other: __________________ yes ___ No
________________________ yes ___ No
________________________ yes ___ No

B. Alternative Communications. You are also entitled to specify alternative, reasonable means of communication, if you do not wish to be contacted by us in a certain way.

I hereby request the following means of contact only: __________________________

Printed Name: __________________ Signature: __________________ Date: ____________
Western Maryland Eye Center

Date: _____________  Account: _____________

Patient Information

First name: ___________ M.I. ___ Last name: ___________
Mailing address: ___________ Apt: ___________
City: ___________ State: ___________ Zip code: ___________
Date of birth: ___________ Marital Status: ___________
Home Phone: ___________ Work Phone: ___________ Cell Phone: ___________
Primary doctor: ___________ Email: ___________
Preferred language: ___________ Ethnicity: Hispanic/Not Hispanic or Latino (Circle one)
Race: American Indian, Alaska native, Asian, African American, Native Hawaiian, White, Other (Circle One)
Patient Employer: ___________ Phone: ___________
Employer address: ___________
Is patient a minor? Yes/No If so, Legal guardians name and relationship: ___________
Does patient have a Power of attorney? Yes/No Name of POA: ___________

Emergency contact information

Name: ___________ Phone: ___________
Relationship: ___________ Address: ___________

Insurance Information

Name of Primary Insurance Company: ___________ Employer: ___________
Name of Insured Member: ___________ D.O.B.: ___________ SS#: ___________
Name of Secondary Insurance Company: ___________ Employer: ___________
Name of Insured Member: ___________ D.O.B.: ___________ SS#: ___________

Electronic Prescription/Medication History Authorization

__I authorize Western Maryland Eye Center to electronically submit any medical prescriptions necessary to my preferred pharmacy. I also authorize Western Maryland Eye Center to obtain my medication history from this pharmacy.

Pharmacy Name: ___________ Location: ___________

-OR-

__I choose not to have my medications sent electronically to the pharmacy by Western Maryland Eye Center.
Acknowledgement of Responsibility and Consent

- I certify that the information I have provided regarding my insurance coverage is correct and authorize Western Maryland Eye Center, Philip J. McGann, M.D., P.A to verify insurance coverage and benefits in accordance with my insurance plan policies.
- I authorize that payments be made directly to Western Maryland Eye Center, Philip J. McGann, M.D., P.A. for all medical insurance benefits which are payable under the terms of my policy for services provided.
- I understand that any copayments, coinsurances or deductibles are contracted between and my insurance company and myself and that I am obligated to pay them in accordance with my insurance policy.
- I agree to accept full financial responsibility for payment if my insurance has been terminated or is not in effect for the dates services are rendered.
- I agree to pay any services provided to me which are considered non-covered under my insurance plan.
- I hereby authorize Western Maryland Eye Center, Philip J. McGann, M.D., P.A. to submit claims to my insurance companies, including Medicare and Medicaid for all services. This authorization also allows for submission of medical records requested by the insurance company.
- I authorize Western Maryland Eye Center, Philip J. McGann, M.D., P.A. to release information about my medical care to my primary care physician to assist in the continuity of my medical health care.

Self Pay Patients

- I do not have insurance coverage or do not want the services provided submitted to my insurance company. I understand that payment for services under these conditions are my sole responsibility.

Authorization for protected health information on voicemail

___ Yes, I authorize Western Maryland Eye Center to leave protected health information as a message on my answering machine or voicemail.

___ No, I do NOT authorize Western Maryland Eye Center to leave protected health information on my answering machine or voicemail.

______________________________
Signature of patient, POA or Legal Guardian  ____________________________
Date
**PATIENT NAME:** ______________________  **DATE:** ______________________  **ACCT. #:** ______________________

**PLEASE LIST ALL MEDICATIONS YOU TAKE, BOTH PRESCRIPTION AND OVER THE COUNTER, INCLUDING VITAMINS:** (If you brought a list with you today, please hand to the front desk with this form and you can skip this section of the questionnaire)

<table>
<thead>
<tr>
<th>NAME OF MEDICATION</th>
<th>DOSAGE</th>
<th>FREQUENCY</th>
</tr>
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<tbody>
<tr>
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</table>

**DO YOU HAVE ANY KNOWN ALLERGIES TO MEDICATIONS? YES / NO**

IF YES, PLEASE LIST THE MEDICATION AND THE ADVERSE REACTION:

<table>
<thead>
<tr>
<th>Medicine</th>
<th>Adverse Reaction</th>
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</tbody>
</table>

**PLEASE LIST ANY SURGERIES YOU HAVE HAD**

<table>
<thead>
<tr>
<th>Surgery</th>
<th>Details</th>
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**FAMILY HISTORY:** HAS ANY MEMBER OF YOUR FAMILY HAD ANY OF THE FOLLOWING? (CIRCLE ALL THAT APPLY)

- Blindness
- Macular Degeneration
- Cataract
- Glaucoma
- Diabetes
- Hypertension
- Heart Disease
- Stroke
- Cancer
- Thyroid Disease
- Arthritis
- Kidney Disease
- Lupus
- Cancer

Other: ______________________

**HAVE YOU BEEN DIAGNOSED WITH ANY DISEASES OR CHRONIC ILLNESSES? IF SO, LIST THEM HERE:**

<table>
<thead>
<tr>
<th>Disease</th>
<th>Details</th>
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</tbody>
</table>
**Pre-Surgery Visual Functioning VF-8R Patient Questionnaire**

Do you have difficulty, even with glasses, with the following activities?

<table>
<thead>
<tr>
<th>Activity</th>
<th>Yes</th>
<th>No</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Reading small print such as labels on medicine bottles, a telephone book or food labels?</td>
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<tr>
<td>If yes, how much difficulty do you currently have?</td>
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<tr>
<td>2. Reading a newspaper or book?</td>
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<tr>
<td>If yes, how much difficulty do you currently have?</td>
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<td>3. Seeing steps, stairs or curbs?</td>
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<td>If yes, how much difficulty do you currently have?</td>
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<td>4. Reading traffic signs, street signs or store signs?</td>
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<tr>
<td>If yes, how much difficulty do you currently have?</td>
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<td>5. Doing fine handwork like sewing, knitting, crocheting or carpentry?</td>
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<tr>
<td>If yes, how much difficulty do you currently have?</td>
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<tr>
<td>6. Writing checks or filling out forms?</td>
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<tr>
<td>If yes, how much difficulty do you currently have?</td>
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<tr>
<td>7. Playing games such as bingo, dominos, card games or mahjong?</td>
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<tr>
<td>If yes, how much difficulty do you currently have?</td>
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<tr>
<td>8. Watching television?</td>
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<tr>
<td>If yes, how much difficulty do you currently have?</td>
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</table>