WESTERN MARYLAND EYE CENTER

PHILIP J. McGANN, MD, PA

1003 W. Seventh St., #400
Frederick, MD 21701
Phone #: 301-662-3721
Fax #: 301-631-5668

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 1196 (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 Hawiian, 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

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1303 W. Seventh St., #400
Frederick, MD 21702
Phone # 301-662-3721
Fax # 301-631-5666

MEDICAL HISTORY QUESTIONAIRRE

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)

NAME OF MEDICATION	DOSAGE	FREQUENCY

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

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

_____

_____

PLEASE LIST ANY SURGERIES YOU HAVE HAD

_____

_____

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:

_____

_____

_____

Outcome PQRS Patient ID: _____ Practice/Surgeon's Name: _____

Site ID as seen in PQRS Registry: _____

Pre-Surgery Visual Functioning VF-8R Patient Questionnaire

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

1. Reading small print such as labels on medicine bottles, a telephone book or food labels?	☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A Little ☐ A Moderate Amount ☐ A Great Deal ☐ Unable to do the activity
2. Reading a newspaper or book?	☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A Little ☐ A Moderate Amount ☐ A Great Deal ☐ Unable to do the activity
3. Seeing steps, stairs or curbs?	☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A Little ☐ A Moderate Amount ☐ A Great Deal ☐ Unable to do the activity
4. Reading traffic signs, street signs or store signs?	☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A Little ☐ A Moderate Amount ☐ A Great Deal ☐ Unable to do the activity
5. Doing fine handwork like sewing, knitting, crocheting or carpentry?	☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A Little ☐ A Moderate Amount ☐ A Great Deal ☐ Unable to do the activity
6. Writing checks or filling out forms?	☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A Little ☐ A Moderate Amount ☐ A Great Deal ☐ Unable to do the activity
7. Playing games such as bingo, dominos, card games or mahjong?	☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A Little ☐ A Moderate Amount ☐ A Great Deal ☐ Unable to do the activity
8. Watching television?	☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A Little ☐ A Moderate Amount ☐ A Great Deal ☐ Unable to do the activity