WESTERN MARYLAND EYE SURGICAL CENTER

PHILIP J. McGANN, MD, PA

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

Patient Name:_____ Acct #_____ Date:_____

## 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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## SEDATION PATIENT

All patients having I.V. sedation for their surgical procedure must be accompanied by an adult friend/family member who can stay in the surgical waiting area during the procedure. They must sign a form acknowledging that they understand that they are responsible to wait while the surgery is being performed. Someone must also stay with the patient for 24 hours to ensure no side effects from the sedation.

By signing below, I acknowledge that I have been informed that I am having I. V. sedation for my surgical procedure and that someone must accompany me and be able to wait on site while my procedure is being performed. If someone does not accompany me, then it will be necessary to reschedule the procedure

## STATEMENT OF FINANCIAL INTEREST

My signature below acknowledges that I have been informed that Philip J. Mcgann, MD established Western Maryland Eye Surgical Center for the convenience of his patients who require surgery and that he has a financial interest in Western Maryland Eye Surgical Center.

## ADVANCE DIRECTIVE NOTICE TO PATIENTS

My signature below indicates that I have been informed that my Advance Directives (if I have them) do not apply to the elective surgery/procedure performed at Western Maryland Eye Surgical Center. I understand that if I provide a copy of my Advance Directives they will be placed in my chart.

In the unlikely event that an emergency arises and I need to be transferred to a hospital for further care, my Advance Directives will be sent with my chart to the receiving hospital.

If I do not have Advanced Directives, my signature below indicates that I have been offered information regarding these health care decisions.

## PATIENT RIGHTS AND RESPONSIBILITIES

My signature below acknowledges that I have received a copy of the Western Maryland Eye Surgical Center Patient Rights and Responsibilities form.

Patient Signature _____ Date_____

Witness _____ Date_____

# WESTERN MARYLAND EYE SURGICAL CENTER
## PATIENT COMMUNICATION FORM

A. Family and Friends. It is the office 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 the "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 this in writing, or call our staff.)

Spouse: _____ _____ yes _____ no

Parent: _____ _____ 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 _____

Patient/Parent/Guardian Signature: _____

Date: _____

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FOR OFFICE USE

Changes to above authorized by patient over phone:

| Change | Date | Staff Initials |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |