Medication List

Joseph Walrath, MD

Oculoplastic Surgeon
800 Mt. Vernon Hwy NE, Suite.120
Atlanta, GA 30328

Please fill in completely, or provide us with a list to photocopy

NAME: _____

Please list all current medications with strengths and your schedule below:

Medication	Strength	AM (?)	PM (?)	Number of times per day?
1)		☐	☐	
2)		☐	☐	
3)		☐	☐	
4)		☐	☐	
5)		☐	☐	
6)		☐	☐	
7)		☐	☐	
8)		☐	☐	
9)		☐	☐	
10)		☐	☐	
11)		☐	☐	

** Pharmacy name and phone number MUST BE FILLED IN COMPLETELY!!**

PHARMACY NAME: _____ **PHONE**: _____

CITY: _____

Please list all allergies to medications and substances:

Substance / Medication	Reaction		Reaction
1)		6)	
2)		7)	
3)		8)	
4)		9)	
5)		10)	

JOSEPH D. WALRATH, MD – OCULOPLASTIC SURGERY

Patient Registration

Name: _____ Today's Date: _____
Last First MI Preferred Name Month/Day/Year

Address: _____
Street City State Zip Code

Home Phone: _____ Work Phone: _____ Cell phone: _____

Email: _____@_____._____ Social Security Number: _____- ____- _____

Age: _____ Date of Birth: _____ Sex: M F Marital Status: S M W D
Month/Day/Year

Spouse or Parent's Name:_____ Spouse's DOB: _____Tel #: _____
Last First Month/Day/Year

Emergency contact not living with you: _____ Relationship: _____

Address: _____ Telephone: _____

What is the name of your primary care physician? _____ Telephone: _____

What is the name of your current optometrist? _____ Telephone: _____

Whom may we thank for this referral? _____

Have you had a recent hospitalization that caused you to spend time in any form of skilled nursing facility? ☐Y ☐N

Are you currently residing in a nursing home/facility? ☐Y ☐N

Preferred method of contact: ☐Home ☐Cell ☐Email **May we leave a message on voice mail/answering machine?** YN

Health Insurance Information

Do you have health insurance? Yes No Medicare? Yes No **Your Medicare Number:** _____

If not Medicare, what is the name of your primary medical insurance? _____

Is the policy holder the above patient? ☐Y ☐N If **no**, policy holder's information must be completed below.

Policy holder name: _____ Relationship: _____

Address: _____Telephone: _____

Date of Birth: _____

Do you have secondary medical insurance? Y N Secondary Insurance Name: _____

For billing purposes, the receptionist will make a copy of your driver's license/picture ID and insurance cards.

Patient name_____ Date_____

These questions are about your race, ethnicity, and primary language. We ask these questions to make sure we are meeting the needs of all of our patients.

Disclosure of below information is completely voluntary.

1. Are you of Hispanic or Latino origin?

☐ Yes
☐ No
☐ Decline
☐ Don't Know

2. Which of the following best describes your race? If necessary, you may select up to two.

☐ Black
☐ White
☐ Asian
☐ American Indian/Alaska Native
☐ Native Hawaiian/Pacific Islander
☐ Decline
☐ Don't Know
☐ Other

3. Please provide <u>one</u> nationality or ethnic group that best describes your ancestry. *(For example, Italian, Jamaican, African American, Haitian, Korean, Lebanese, etc.)*

☐ African American
☐ Albanian
☐ Belgian
☐ Bangladeshi
☐ Chaldean
☐ Chinese
☐ Chippewa/Ojibwe
☐ Cuban
☐ Czechoslovakian
☐ Dutch
☐ Egyptian
☐ English
☐ Filipino
☐ Finnish
☐ French
☐ German
☐ Greek
☐ Haitian
☐ Hawaiian
☐ Huron
☐ Indian (Not Native Amer)
☐ Iranian
☐ Iraqi Indian (East Asian)
☐ Irish
☐ Italian
☐ Jamaican
☐ Japanese
☐ Jordanian
☐ Korean
☐ Lebanese
☐ Macedonian
☐ Mexican
☐ Nigerian
☐ Ottawa/Odawa
☐ Palestinian
☐ Persian
☐ Polish
☐ Potawatomi
☐ Puerto Rican
☐ Romanian
☐ Russian
☐ Scottish
☐ Spanish (Spain)
☐ Syrian
☐ Ukrainian
☐ Vietnamese
☐ Decline
☐ Don't Know
☐ Other (specify)_____

4. How would you rate your ability to speak English?

☐ Very well
☐ Well
☐ Not well
☐ Not at all
☐ Decline
☐ Don't Know

5. What language do you feel most comfortable using when discussing your health care?

☐ American Sign Language
☐ Albanian
☐ Arabic
☐ Bengali
☐ Cantonese
☐ English
☐ Italian
☐ Mandarin
☐ Russian
☐ Spanish
☐ Vietnamese
☐ Yemen Arabic
☐ Decline
☐ Don't know
☐ Other (specify)_____

Thank you. Please return this form to the front desk staff person WEI representative.

For billing purposes, our receptionist will make a copy of your insurance plan cards.

JOSEPH D. WALRATH, MD – OCULOPLASTIC SURGERY

Financial Agreement and Policies

Financial Policy/Insurance Submissions

Payment in full is required at the time of service for all past due balances, deductible amounts that have not been met, non-insured patients and any other coverage that could not be verified at the time of service. As the patient you are required to pay the co- pay/coinsurance at the time of service. Claims are billed to the insurance carrier as a courtesy; however, you are responsible for payment of all charges incurred. Please be advised there are some clinical and surgical procedures that your insurance will not cover; therefore, by signing this document, you agree to be held financially responsible for services rendered on or before the time of surgical or clinical service. All balances not paid by the insurance carrier within 90 days of the date of service will be your responsibility. We will be happy to refund you for any payments made by you after your insurance company has paid in full for covered services.

Dr. Walrath/Woolfson Eye Institute will make all effort possible to obtain insurance verification and coverage benefits prior to appointments but it is also the patient's obligation and responsibility to ensure that Dr. Walrath/Woolfson Eye Institute is a participating provider under the patient's health plan and the patient is knowledgeable in regards to their health coverage and benefit policy.

_____Initial – I have read and agree to the above statements.

Insurance Changes

If you have any changes to your insurance information, please notify our office immediately. Dr. Walrath/Woolfson Eye Institute will not be responsible for timely filing if we do not receive the correct insurance information prior to or at the time of the visit. I understand it is mandatory to notify my provider of any other insurance responsible for paying for treatment.

_____Initial – I have read and agree to the above statement.

Returned Checks

All checks returned for insufficient funds, closed accounts, or for any other reason will be subject to a $25.00 service charge. All further payments must be made either by credit card, money orders or cash.

_____Initial – I have read and agree to the above statement.

Deductibles/Coinsurance/Co-payments

Deductibles, coinsurance and co-payments will be collected at the time services are rendered. These are required by your insurance company and agreed upon by you when you accept their insurance. We also must contract with insurance companies, agreeing to collect co-payments, coinsurance and deductibles in order to participate with their plans.

_____Initial – I have read and agree to the above statement.

Collection Policy

Any balances not paid within 90 days from the date the charge is turned over to patient responsibility will be turned over to an outside collection agency. Balances are turned over to patient responsibility once insurance has processed the claim and determined patient responsibility. Balances will also be turned over to patient responsibility if insurance is unable to process claims due to missing or incomplete information not provided by policy holder to their insurance company. Any account turned over to collections will be assessed a collection fee of 30% of the total amount due.

_____Initial – I have read and agree to the above statement.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact the billing office promptly (WEI billing office 770-516-1775) for assistance in the management of your account. We would be willing to discuss reasonable payment plans. If you have any question about the above information, please do not hesitate to ask us.

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and any other health plan to Dr. Walrath/Woolfson Eye Institute. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges, whether or not these charges are paid by my medical insurance. I hereby authorize Dr. Walrath/Woolfson Eye Institute to release any and all information necessary to secure payment.

Please Print Name: _____

Signed: _____Date: _____

Witnessed by staff member: _____ Date: _____

JOSEPH D. WALRATH, MD – OCULOPLASTIC SURGERY
800 MT. VERNON HWY NE SUITE 120
ATLANTA, GA 30328
SURGICAL COORDINATORS: (770)804-1684 EXT.119 or 166
APPOINTMENTS/CALL CENTER: (866) 527-3722

NOTICE OF PRIVACY PRACTICES
PHI-Protected Health Information

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU. The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will elaborate on the meaning and provide more specific examples, if you request. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories. We must obtain your authorization before the use and disclosure of any psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosure that constitute a sale of PHI. Uses and disclosures not described in this Notice of Privacy Practices will be made only with authorization from the individual.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive at the Practice may be billed to and payment may be collected from you, an insurance company or a third party. For example: we may disclose your record to an insurance company, so that we can get paid for treating you. **For Treatment.** We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at the Practice or the hospital. For example, we may disclose medical information about you to people outside the Practice who may be involved in your medical care, such as family members, clergy or other persons that are part of your care.

For Health Care Operations. We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run the Practice and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other Practice personnel for review and learning purposes. For example, we may review your record to assist our quality improvement efforts. **WHO WILL FOLLOW THIS NOTICE?** This notice describes our Practice's policies and procedures and that of any health care professional authorized to enter information into your medical chart, any member of a volunteer group which we allow to help you, as well as all employees, staff and other Practice personnel.

POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION. We create a record of the care and services you receive at the Practice. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the Practice, whether made by Practice personnel or by your personal doctor. The law requires us to: make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and to follow the terms of the notice that is currently in effect. Other ways we may use or disclose your protected healthcare information include: appointment reminders; as required by law; for health-related benefits and services; to individuals involved in your care or payment for your care; research; to avert a serious threat to health or safety; and for treatment alternatives. Other uses and disclosures of your personal information could include disclosure to, or for: coroners, medical examiners and funeral directors; health oversight activities; inmates; law enforcement; lawsuits and disputes; military and veterans; national security and intelligence activities; organ and tissue donation; protective services for the President and others; public health risks; and worker's compensation.

NOTICE OF INDIVIDUAL RIGHTS

You have the following rights regarding medical information we maintain about you:

Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. We may deny your request to inspect and copy in certain very limited circumstances.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, the Practice. To request an amendment, your request must be made in writing and submitted to the Privacy Officer and you must provide a reason that supports your request. We may deny your request for an amendment.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. ***We are not required to agree to your request.*** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer.

Right to Request Removal from Fundraising Communications. You have the right to opt out of receiving fundraising communications from the Practice.

Right to Restrict Disclosures to Health Plan. You have the right to restrict disclosures of PHI to a health plan if the disclosure is for payment of health care operations and pertains to a health care item or service for which the individual has paid out of pocket in full.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must make your request in writing and you must specify how or where you wish to be contacted.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer.

CHANGES TO THIS NOTICE. We reserve the right to change this notice. We will post a copy of the current notice in the Practice's waiting room.

COMPLAINTS. If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact Doug Frye, Privacy Officer, (770) 921-4300, 627 Beaver Ruin Road, Suite B, Lilburn, GA 30047. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

OTHER USES OF MEDICAL INFORMATION. Other uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time.

If you have any questions about this notice or would like to receive a more detailed explanation, please contact our Privacy Officer.

I acknowledge by signing below that I have received the Notice of Privacy Practices and Notice of Individual Rights.

I give authorization for Joseph Walrath, MD/Woolfson Eye Institute to discuss appointment/rescheduling details/medical information if necessary with:

Name_____ Relationship_____ Phone number_____

Name _____ Relationship_____ Phone number_____

Patient or Patient's Personal Representative_____ **Date**_____

Staff Witness_____ Date_____

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Federally Mandated Smoking Status and Vaccination Status Form

Patient Name: _____

Date of Birth: _____

Date of Service: _____

Do you smoke? (Please circle one): YES NO

Packs per day: _____

Have you had the pneumonia vaccine? (Please circle one): **YES** **NO**

If yes, date of vaccination: _____

Have you had a flu vaccination? (Please circle one): **YES** **NO**

If yes, date of vaccination: _____