PATIENT INFORMATION

Name: _____ Soc. Sec.# _____
Last Name First Name Initial

Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____ Cell Phone: _____

Sex: M ☐ F ☐ Age: _____ Birthdate: _____ E-mail: _____

Patient Employed by: _____ Occupation: _____

Business Address: _____ Business Phone: _____

Spouse's Name: _____ Date of Birth: _____

Family Physician: _____ Phone: _____

Whom may we thank for referring you? _____ Your Optometrist: _____

What is your reason for visit? _____ Last exam date: _____

Do you have difficulty hearing? Yes ___ No ___ If so, have you sought help for your hearing problem? Yes ___ No ___

Would you be interested in receiving a complimentary hearing evaluation by a certified Audiologist? Yes ___ No ___

Do you wear hearing aids? Yes ___ No ___ If so, are you satisfied with their performance? Yes ___ No ___

In case of emergency list the nearest friend or relative not living with you. Relationship: _____

Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

INSURANCE INFORMATION

Person responsible for the bill: _____
Last Name First Name Initial

Relationship to the patient: _____ Birthdate: _____ Soc. Sec.# _____

Address (if different from the patient's) _____ Phone: _____

City: _____ State: _____ Zip _____

Person Responsible Employed by: _____ Occupation: _____

Business Address: _____ Business Phone: _____

Insurance Company: _____

Contact # _____ Group # _____ Subscriber I.D. # _____

AUTHORIZATIONS

I, the undersigned, have insurance coverage with _____

And assign directly to **Kenya M. Williams, MD** all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid for by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____
Signature of Insured Guardian Date

INSURANCE AUTHORIZATION

I request that payment of authorized insurance benefits be made either to me or on my behalf to **Kenya M. Williams, MD** for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services. I understand my signature requests that payment be made and authorized release of medical information necessary to pay the claim. If " other health insurance" is indicated in item 9 of the HFCA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the insurance carrier.

_____ _____
Signature of Insured Guardian Date

PLEASE FILL OUT ADDITIONAL INFORMATION ON REVERSE SIDE

PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name_____ Birthdate_____

Signature_____ Date_____

INFORMATION REGARDING DILATING EYE DROPS

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye.

Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it's best if you make arrangements not to drive yourself.

Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize Dr._____and/or such assistants as may be designated by him/her to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

Patient_____ Date_____

Witness_____ Date_____

PLEASE INITIAL EACH LINE AND SIGN AT THE BOTTOM

_____ Patients are responsible for providing this office with current insurance information at each visit. Claims denied for insufficient/incorrect information will be my responsibility.

_____ Patients must bring my current insurance cards and referral (if required) to each appointment or the appointment may be rescheduled.

_____ Patients are responsible for verifying insurance coverage and making sure that we are a network provider.

_____ Co-pays, deductibles, account balances, aesthetic procedures and refraction charges are due at the time that the service is rendered or the appointment may be rescheduled.

_____ Payments collected for procedures are estimates and accounts will be reconciled after your insurance company processes the claim. You will be billed for any remaining balance.

_____ We request a 24 hour cancellation notice. Failure to reschedule or cancel appointments may be charged a $25.00 administrative fee that is not billable to insurance.

_____ We attempt to make courtesy reminder phone calls prior to your appointment but may be unable to provide this service at all times. Lack of a reminder call does not negate the above no-show administrative fee.

_____ All returned checks will be charged a $35.00 administrative fee and your account may be placed on a cash only basis.

_____ Invoices are due upon receipt.

_____ There is an administrative fee of 25.00 for filling out forms. Payment is due at the time of submission.

_____ There is a charge for copying medical records. The first 10 pages are free, for each additional page it is 1.00.

I have read, understand and will comply with the practice policies above.

_____ _____

Signature Name

_____ _____

Relationship Date

PATIENT HISTORY FORM

NAME _____ **Date** _____

Last **First** **MI**

DOB _____ **Age**_____ **Sex** ❑ **M** ❑ **F**

How did you hear about us?

Briefly describe your present symptoms

Please list the names of other practitioners you have seen for this problem

MEDICATION HISTORY
Drug allergies and reaction
List **ALL** prescribed and over the counter or herbal **ORAL** medications
Ocular medications

PAST MEDICAL HISTORY

Do you now or have you ever had

- ❑ Diabetes
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Hypothyroidism
- ❑ Goiter
- ❑ Cancer (type) _____
- ❑ Leukemia
- ❑ Psoriasis
- ❑ Angina
- ❑ Heart problems
- ❑ Heart murmur
- ❑ Pneumonia
- ❑ Pulmonary embolism
- ❑ Asthma
- ❑ Emphysema
- ❑ Stroke
- ❑ Epilepsy (seizures)
- ❑ Cataracts
- ❑ Kidney disease
- ❑ Kidney stones
- ❑ Crohn's disease
- ❑ Colitis
- ❑ Anemia
- ❑ Jaundice
- ❑ Hepatitis
- ❑ Stomach or peptic ulcer
- ❑ Rheumatic fever
- ❑ Tuberculosis
- ❑ HIV/AIDS

Other medical conditions (please list)

SYSTEMS REVIEW

In the past month, have you had any of the following problems?

GENERAL
- ❑ Recent weight gain
- ❑ Recent weight loss
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever
- ❑ Night sweats

MUSCLE/JOINTS/BONES
- ❑ Numbness
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Joint swelling

Where?

EARS
- ❑ Ringing in ears
- ❑ Loss of hearing

EYES
- ❑ Pain
- ❑ Redness
- ❑ Loss of vision
- ❑ Double or blurred vision
- ❑ Dryness

NERVOUS SYSTEM
- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting or loss of consciousness
- ❑ Numbness or tingling
- ❑ Memory loss

STOMACH AND INTESTINES
- ❑ Nausea
- ❑ Heartburn
- ❑ Stomach pain
- ❑ Vomiting
- ❑ Yellow jaundice
- ❑ Increasing constipation
- ❑ Persistent diarrhea
- ❑ Blood in stools
- ❑ Black stools

KIDNEY/URINE/BLADDER
- ❑ Frequent or painful urination
- ❑ Blood in urine

THROAT
- ❑ Frequent sore throats
- ❑ Hoarseness
- ❑ Difficulty in swallowing
- ❑ Pain in jaw

PSYCHIATRIC
- ❑ Depression
- ❑ Excessive worries
- ❑ Thoughts of suicide / attempts

HEART AND LUNGS
- ❑ Chest pain
- ❑ Palpitations
- ❑ Shortness of breath
- ❑ Fainting
- ❑ Swollen legs or feet
- ❑ Cough

WOMEN ONLY
- ❑ Abnormal Pap smear
- ❑ Irregular periods
- ❑ Bleeding between periods
- ❑ PMS

BLOOD
- ❑ Anemia
- ❑ Clots

Chicago Oculofacial Consultants
Ophthalmic and Facial Plastic Surgery
Kenya M Williams MD

chicagoeyeandface.com

Informed Consent for Telemedicine Services

PATIENT NAME _____ MR _____

Introduction
Telemedicine involves the use of electronic communications (telephone, computer, etc.) to enable health care providers (doctors, nurses, physician assistants, and others) at a different location from the patient to share medical information with that patient for the purpose of improving access to patient care. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following

- Patient medical records, medical images, live two-way audio and video, output data from medical devices and sound and video files.

The electronic systems used will attempt to incorporate security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against corruption.

Expected Benefits

- Improved access to medical care by enabling a patient to remain in his/her location while the healthcare provider provides medical information from a distant site
- Limiting the spread of COVID-19 and other communicable diseases
- Ability to obtain consultation from a distant medical specialist without traveling
- Conservation of personal protective equipment (PPE) such as gloves and masks to reduce shortages for healthcare providers
- Allow medical evaluation and management of patients who are unable to travel

Possible Risks
As with any medical procedure, there are risks associated with the use of telemedicine. These risks include, but may not be limited to

- Information transmitted may not be sufficient to allow for appropriate medical decision. making by the health care provider. For instance, certain parameters of the eye examination cannot be tested remotely, such as eye pressure. In addition, there may be poor resolution of images. This may cause a delay in medical evaluation and treatment.
- Security protocols could fail, causing a breach of privacy of personal medical information.

- A lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other medical errors.

PATIENT'S ACCEPTANCE OF RISKS By signing this form, I understand that

The laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine will be disclosed to researchers or other entities without my consent.

I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.

I have the right to inspect all information obtained and recorded in the course of a telemedicine interaction and may receive copies of this information for a reasonable fee.

Telemedicine may involve electronic communication of my personal medical information to other medical practitioners located elsewhere, including out of state.

I understand that no results from the use of telemedicine can be guaranteed or assured.

Consent By signing below, you consent (agree) that

- You have read this informed consent form, or someone has read it to you.
- You understand the information in this informed consent form and all of your questions have been answered.
- You have been offered a copy of this informed consent form.

I hereby authorize Kenya M. Williams MD to use telemedicine in the course of my diagnosis and treatment.

_____ _____

Signature of Patient (or person authorized to sign for patient) Date

If authorized signer, relationship to patient

_____ _____

Date