Fredrick A. Isaacs, M.D.,P.C.,F.A.C.S.

First Name_____M.I.____Last Name_____
Social Security_____-____-_____ Sex: M F Birthdate:___/___/___Marital Status: M S D W

Street Address_____
City_____State_____Zipcode_____
Home Phone:_____Cell:_____Work:_____
Email:_____

Employed: FT/PT/NONE Employer:_____

Emergency Contact: (Someone who **DOES NOT** reside with you)
Name:_____Number:_____
Relationship:_____

Disclosure Of Information

Name or specifically identify the persons and/or entities you are authorizing Dr.Isaacs and staff to disclose medical information to:

_____

Name of authorized person or entity	Relationship	Phone #

_____

Name of authorized person or entity	Relationship	Phone #

AUTHORIZATION FOR USE OF ANSWERING MACHINE AND/OR VOICEMAIL

Dr. Isaacs and staff are routinely unable to contact patients directly during normal business hours. On these occasions our office leaves messages on communication devices provided by our patients. Due to the newly mandated HIPAA Privacy Rule we must obtain your authorization to continue this mode of communication. Protected health information that we may possibly disclose on your home, work or cell phone would include, but not limited to: test/lab results, prescription/pharmacy information, appointment instructions for visits and procedures, and surgical posting/scheduling information.

_____(Initial) I agree to allow Dr. Isaacs and staff to leave messages that include Protected Health Information at the following locations. Please initial next to applicable:
_____home number, _____work number or _____cell number

_____(Initial) No, I do not wish for Dr. Isaacs and/or staff to leave messages that include Protected Health Information.

_____

Signature Date

I hereby authorize Fredrick A. Isaacs M.D. to apply for benefits on my behalf for covered services rendered. I certify that the information I have reported with regard to my insurance coverage is correct. I further authorize the release of any necessary information, including medical information for this or any related claim, to my insurance carrier, (or in the case of Medicare Part B benefits to the Social Security Administration and Health Care Financing Administration). A copy of the authorization may be used in place of the original. This authorization may be revoked by either my insurance carrier or me at any time in writing.

ASSIGNMENT OF BENEFITS

I hereby authorize payment of all medical insurance benefits which are payable to me under the terms of my insurance policy to be paid directly to Fredrick A. Isaacs M.D. for services rendered. I further authorize the release of any information needed for processing my insurance claims. A copy of this authorization may be used in place of the original. I understand and agree that I am financially responsible for charges not paid by my insurance company.

FINANCIAL AGREEMENT

I hereby assume financial responsibility for and agree to make payment in full to Fredrick A. Isaacs M.D. for all charges for services or medical supplies furnished to me by Fredrick A. Isaacs M.D not otherwise covered by my insurance carrier. Payment is to be made within 30 days as statements are presented with settlement in full.

COLLECTION FEES

Should Fredrick A. Isaacs M.D , refer my account to a collection agency and/or attorney for collection, I agree to pay all collection costs, including but not limited to court costs and attorney fees of 35 percent of my bill. I understand that all delinquent accounts shall bear interest at the rate of 12 percent per annum.

×_____ _____

Signature of patient,insured, or beneficiary Date

FOR MEDICARE PART B PATIENTS ONLY

I understand that in certain circumstances medicare may decide that appropriate medical services are not medically reasonable or necessary under the Medicare Law. Since Medicare may deny payment for these services, I agree to be personally and fully responsible for payment of these charges.

×_____ _____

Signature of patient,insured, or beneficiary Date

Patient Responsibilities

Patient Name:_____DOB:_____

1. Notify us of any changes in your address or insurance information at the time of the change.

2. You must provide us with a copy of your photo id and current valid health insurance card to provide proof of insurance. If you fail to provide us with the correct information you will be responsible for the balance of the claim.

3. Know your insurance policy. Every policy has its own rules and regulations. It is in your best interest to know what your policies are, and if referrals are required. If you arrive without a referral you understand that this means you become responsible for this service.

4. We order tests that are medically necessary. It is your responsibility to know what tests your insurance policy covers and does not cover. (This includes all lab and radiology tests.)

5. All appointments must be scheduled in advance. Same day appointments are available for emergencies but must be scheduled. A $40 No Show or Late Cancellation fee will apply if you do not cancel your appointment with 24 hours notice or do not show for your appointment.

6. Co-payments/Refraction Fee/co-insurances and deductibles must be made at the time services are rendered. We will not bill for these. (This is a health insurance requirement.) If you are due a refund please note that you will be refunded in the same manner of which you paid.

7. Pay your bill promptly. If there is an extreme financial hardship, please contact our billing department at 301-598-8500 in advance of appointment.

8. If your check is dishonored or returned for any reason you will be charged a processing fee of $35 00.

9. When needing a prescription refill we will require 48 hours from the time of your call to process your request. Refill requests will only be filled during normal business hours.

10. If you need us to complete a form please bring it in as early as possible. Due to the large volume of forms we receive it may take up to 2 weeks to complete. If you need to have a form filled out there will be a charge ranging from $20- $150.

11. If you are scheduled for surgery and need to cancel please give the office 2 weeks notice to avoid a cancellation charge of $150.

I _____ have read and understand the above policies.

Patient Signature:_____Date:_____

Patient Acknowledgement & Consent Form

Acknowledgement of Notification

The educational pamphlet entitled "Notice of Privacy Practices" provides information about how we may use and disclose protected health information about you, and is compliant with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our **Notice Of Privacy Practices** states that we reserve the right to change the terms described. Should this happen, we will post the changes in our office.

You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, or health care operations. We are not required to agree to your restrictions; but if we do, we are bound by our agreement with you.
By signing below, you acknowledge receipt of our **Notice of Privacy Practices.**

Patient's Signature Date

Consent for Use and Disclosure of Information

By signing below, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in trust on your prior consent.

I request that payment of authorized Medicare/Insurance carrier benefits be made on my behalf to Dr.Fredrick Isaacs for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare/Medicaid Services and its agent and/or any other Insurance Carriers for which I have coverage, any information needed to determine these benefits or the benefits payable for related services. I agree to provide all referral and treatment plan(s) as required by my insurance carrier(s). All co-pays and refractions must be paid at time of service in accordance with the contracted Insurance Carrier agreements

Patient's Signature Date

Print Full Name DOB

MEDICAL HISTORY QUESTIONNAIRE

Name:_____ Date of Birth:___/___/___
Primary Care Physician:_____ Referring Dr:_____
Pharmacy:_____ Location:_____

Race: WHITE BLACK ASIAN OTHER

Ethnicity: HISPANIC NOT HISPANIC

Preferred Language: English French Portuguese Italian Japanese, Spanish
Other:_____

Allergies to Medications:

_____ _____ Mild/Moderate/Severe
_____ _____ Mild/Moderate/Severe

Current Eye Medications: (Please List)

_____
_____

Smoking: Current everyday smoker Former smoker Never smoked

Alcohol Use: YES NO If yes how much and how often_____
Drug Use: YES NO If yes how much and how often_____

Have You had any of the following Vaccines? Please Circle

Pneumonia--YES or NO Flu--YES or NO Covid--YES or No

Other Current Medications: Please use back of page if you need more space

Medication	Dose	Frequency

Family History: **PLEASE INDICATE:**

M=mother F=father S=sibling GP=grandparent
L=living D=deceased

DISEASE	YES	NO	RELATIONSHIP
ARTHRITIS			
BLINDNESS			
CANCER			
CATARACTS			
DIABETES			
GLAUCOMA			
HEART DISEASE or HIGH BLOOD PRESSURE			
KIDNEY DISEASE			
LAZY EYE			
MACULAR DEGENERATION			
RETINAL DISEASE			
STROKE			

Past Ocular History: (Please circle all that apply)
Overall Healthy Cataracts Hyperopia(farsighted) Iritis Optic Neuritis
Myopia(nearsighted) Amblyopia(Lazy Eye) Dry Eyes Keratoconus Retinal Detachment
Astigmatism Glaucoma Macular Degeneration Other:_____

Ocular Surgeries:(Please circle all that apply)
No prior ocular surgery Foreign Body Removal Punctal Plugs Blepharoplasty
Trabeculectomy Cataract Surgery Retinal Laser Surgery LASIK
Strabismus Surgery Vitrectomy Corneal Transplant Other:_____

Ocular Significant Illnesses:(Please circle all that apply)
Overall Healthy Herpes Hypothyroidism Sjogrens AIDS HIV positive
Lupus Graves Disease Diabetes Hypertension Multiple Sclerosis
Hyperthyroidism Rheumatoid Arthritis Other:_____

Infections: (Please circle all that apply):Overall Healthy Herpes Simplex HIV/AIDS
Syphilis Chicken Pox Meningitis Herpes Zoster/Shingles Hepatitis
A/B/C MRSA Wound infection Other:_____

Systemic Illnesses:

No History Of Illnesses	Congestive Heart Failure	Hepatitis	Lung Disease
Anemia	COPD	Lupus	Migraine
Arthritis	High Blood Pressure	Diabetes	HIV
Arrhythmia	High Cholesterol	Eczema	Polymyalgia
Asthma	Fibromyalgia	Headache	Cancer
Kidney Disease	Psychiatric Disorder	Stroke	Hearing Loss
Kidney Stones	Bleeding Disorder	Skin Cancer	Thyroid Disease
Liver Disease	Other:_____		

Review of systems: (Please mark all that apply)

Eyes	Respiratory	Blood/Lymph nodes
Previous Surgery	Cough	Easy Bruising
Contact Lens	Wheezing	Gums Bleed Easy
Pain	Asthma	Prolonged Bleeding
Double Vision		Heavy Aspirin Use
Glaucoma		
Cataracts	Gastrointestinal	MusculoSkeletal
Macular Degeneration	Heartburn	Stiffness
Dry Eyes	Nausea/Vomiting	Arthritis
Flashes	Jaundice/Hepatitis	Joint Pain/Swelling
Floaters		

Ear, Nose and Throat	Genito-Urinary	Skin
Hard of Hearing	Pain/ Difficulty	Rash/Sores
Ringing in Ears	Blood in Urine	Lesions
Vertigo	History of Kidney Stones	Hives/Eczema
	History of STD's	

Cardiovascular	Psychiatric	Neurological
Chest Pain	Anxiety/Depression	Seizures
Dizziness	Mood Swings	Weakness/Paralysis
Shortness of Breath	Difficulty Sleeping	Numbness
Fainting Spells		Tremors
Irregular Heartbeat		
Difficulty Lying Flat		

Constitutional	Endocrine	Immunologic
Fatigue/Weakness	Increased Thirst	Hives
Fever	Increased Hunger	Itching
Weight Gain / Loss	Increased Urination	Runny Nose
	Increased Sweating	Sinus Pressure