JONATHAN S LYONS MD, THOMAS H YAU MD, LLC
ROBERT P FRIEDLAENDER MD
ARUSHA GUPTA MD
EYE PHYSICIANS AND SURGEONS
8630 Fenton Street, Suite 514
Silver Spring MD 20910
301-587-1220

PATIENT INFORMATION FORM

(PLEASE CIRCLE)

Mr/Mrs/Ms _____ **DATE OF BIRTH**_____**AGE**_____

ADDRESS _____ **HOME PHONE**_____

_____ **SOCIAL SECURITY NUMBER**_____

MARITAL STATUS _____

WORK ADDRESS_____ **WORK PHONE**_____

_____ **CELL PHONE:** _____

OCCUPATION _____ **Email:**_____
(CURRENT OR PREVIOUS)

EMERGENCY CONTACT_____ **PHONE** _____

PRIMARY PHYSICIAN _____ **PHONE**_____

ADDRESS_____

HEALTH INSURANCE INFORMATION

DO YOU HAVE MEDICARE? ____YES ____NO IS MEDICARE YOUR PRIMARY INSURANCE? ___YES ___NO
MEDICARE NUMBER & LETTER_____

DO YOU HAVE OTHER HEALTH INSURANCE? ___YES ___NO

INSURED'S NAME _____ **RELATION TO YOU**_____

INSURANCE Company _____ **ID NUMBER** _____

GROUP NUMBER _____ **INSURED'S DATE OF BIRTH**_____

CLAIMS ADDRESS _____

_____

Job related injury/workman's compensation? (Y/N)

I was referred by: (if physician, please give name, address, and telephone)

_____

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Robert Friedlaender MD, Arusha Gupta MD
Eye Physicians and Surgeons
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General Medical Questionnaire

Name:_____ Birth Date:_____
Height:_____ Weight:_____

Current Medications
(or enclose list):

Previous Surgeries:

Do you have any medication allergies?

Did you ever smoke?
If so, how long?

Family history of any eye diseases?

Medical History/Review of Systems:
Please check if applicable and elaborate:

1 Glaucoma_____
2 Macular degeneration _____
3 High Blood Pressure_____
4 Diabetes_____
5 High Cholesterol_____
6 Heart Disease_____
7 Stroke_____
8 Arthritis_____
9 Cancer (with type):_____
10 Malaise_____
11 Ears, Nose, Throat_____
12 Lungs_____
13 Heart_____
14 Digestive_____
15 Musculoskeletal_____
16 Genitourinary_____
17 Psychiatric_____
18 Neurological_____
19 Hematological/Anemia_____
Other:_____

HIPAA Notice of Privacy Practices

Jonathan Lyons MD & Thomas Yau MD LLC
Arusha Gupta MD
Robert Friedlaender MD
8630 Fenton Street Suite 514
Silver Spring MD 20910
301-587-1220

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law .

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:_____ Signature_____Date_____

HIPAA Notice of Privacy Practices

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Signature_____Date_____ Print Name:_____

I give permission **for telephone messages to be left at my home, answering machine, or voice mail**. I give permission for **reminder cards to be sent** for future appointments.

Signature_____Date_____

By signing below, I give permission to the office of **Jonathan Lyons MD and Thomas Yau MD LLC, Arusha Gupta, or Robert Friedlaender MD** to discuss my Protected Health Information with the following persons:

Name:_____ Relationship:_____Phone#: _____

Name:_____ Relationship:_____Phone#:_____

Signature_____Date_____

JONATHAN S. LYONS MD & THOMAS H. YAU MD, LLC
ARUSHA GUPTA MD
ROBERT P. FRIEDLAENDER MD

Ophthalmology & Ophthalmic Surgery
Retina Electrophysiology

8630 Fenton Street
Silver Spring, MD 20910
T: 301-587-1220
F: 301-587-1269

I request that payment of authorized insurance benefits be made either to me or on my behalf to Jonathan S. Lyons, MD, Thomas H. Yau, MD, Robert P. Friedlaender, MD, And Arusha Gupta MD for any services furnished to me by that physician or supplier. 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 for related services.

Patient Signature Date

I have been informed that Medicare or other insurance will only pay for services that it determines to be "reasonable and necessary". I have been notified that Medicare or other insurance may deny payment for the test(s) and other treatment(s) determined by me and my doctor to be appropriate. This expense will be billed to the insurance carrier in accordance with their contractual agreement. I agree to pay in full for this service/ product/ equipment and "non-covered services" if the bill submitted to my insurance carrier is denied for reimbursement. I understand that if my insurance requires a referral and I do not bring one, I will be responsible for the bill.

Patient Signature Date