Joseph Walrath, MD

Ophthalmic Plastic Surgery
800 Mt. Vernon Hwy NE, Ste. 125
Atlanta, GA 30328

NAME: ________________________________

Please list all current medications with strengths and your schedule, and pharmacy information (additional sheets available):

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

PHARMACY NAME: __________________________ PHONE: ________________

CITY: ____

Please list all allergies to medications and substances:

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

Patient Registration – Insurance Covered

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? ____

Pharmacy Name: __________________ Telephone: ______________

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/facilty? ☐ Y ☐ N

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

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: ________________________

Please complete both sides of this form. Thank you.

For billing purposes, our receptionist will make a copy of your insurance plan 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 one 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 Walrath, MD
WEI - Atlanta, GA
404-662-2266

Notice of Privacy Practices

Patient Health Information
Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment and related medical information. Your health information also includes payment, billing and insurance information.

How We Use Your Patient Health Information
We use health information about you for treatment, to obtain payment, and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose the information even without your permission.

Examples of Treatment, Payment and Health Care Operations
Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care.

Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payment from your health plan.

Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration or records, evaluation of the quality of treatment, and to assess the care and outcomes of your case and others like it.

Special Uses
We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Other Uses and Disclosures
We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the following purposes:

Required by Law: We may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.

Research: We may use or disclose information for approved medical research.

Public Health Activities: As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.

Health Oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.

Judicial and Administrative Proceedings: We may disclose information in response to an appropriate subpoena or court order.

Law Enforcement Purposes: Subject to certain restrictions, we may disclose information required by law enforcement officials.

Deaths: We may report information regarding deaths to coroners, medical examiners, funeral directors and organ donor agencies.

Serious Threat to Health or Safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Military and Special Government Functions: If you are a member of the Armed Forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.

Workers' Compensation: We may release information about you for Workers' Compensation or similar programs providing benefits for work-related injuries or illness.

If any other situation arises, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

Individual Rights
You have the following rights with regard to your health information. Please contact the person listed below to obtain the appropriate form for exercising these rights.

Request Restrictions: You may request restrictions on certain uses and disclosures of your health information. We are not required to agree to such restrictions, but if we do agree, we must abide by those restrictions.

Confidential Communications: You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.

Inspect and Obtain Copies: In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for the copies.

Amend Information: If you believe that information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

Accounting of Disclosures: You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment or health care operations.

Our Legal Duty
We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protecting health information, and to abide by the terms of the Notice currently in effect.

Changes in Privacy Practices
We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the waiting area and each examination room. You can also request a copy of our Notice at any time. For more information about our privacy practices, contact the person listed below.

Complaints
If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the person named below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address, upon request. You will not be penalized in any way for filing a complaint.

Contact Person
For any questions, requests or complaints, please contact:

Amy Carlson-Jacko, Privacy Officer
Woolfson Eye Institute (WEI)
800 Mt. Vernon Highway, Suite 120
Atlanta, GA 30328
(866) 527-3722
acarlson-jacko@woolfsoneye.com

Effective Date: July 26, 2010

I, ______________________________ hereby acknowledge receipt of the Notice of Privacy Practices given to me.
The way I wish to be contacted for appointment reminders or follow-ups is: (___)____-_____ Home Phone (___)____-_____ Cell Phone ________________ Email

I give authorization for Woolfson Eye Institute to discuss appointment details and rescheduling, if necessary, with:

Name: ______________________ Relationship: ____________ Phone Number: __________________

Name: ______________________ Relationship: ____________ Phone Number: __________________

Signed: ________________________________ Date: __________________

Staff Witness: ________________________________ Date: __________________

JOSEPH D. WALRATH, MD – OCULOPLASTIC SURGERY
800 MT. VERNON HWY NE
SUITE 135
ATLANTA, GA 30328

COORDINATOR: 770-804-1684 EXT.119
CALL CENTER: 866-527-3722

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.

Social Security Number

Our office policy requires your social security number be provided for billing and insurance purposes. By declining to provide us with a social security number, you agree to pay for your services prior to services being rendered.

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

JOSEPH D. WALRATH, MD – OCULOPLASTIC SURGERY
800 MT. VERNON HWY NE
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ATLANTA, GA 30328

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CALL CENTER: 866-527-3722

Surgical Predetermination Process

Predetermination takes place prior to surgery and requires that a letter of medical necessity, any photographs and/or testing be sent to your insurance company for review and possible approval. This process can take four to six weeks, and if surgery is approves, there is no guarantee of payment. *Should you wish to proceed with an unapproved surgical procedure, you will be asked to sign the waiver in lieu of insurance claim filing, and we will ask for payment in full. Dr. Walrath/Woolfson Eye Institute will not refund any private pay monies collected on an unapproved surgery. You may wish to file the claim on your own and agree to accept what your insurance company PAYS YOU after the surgery has taken place.*

______________________Initial – I have read and agree to the above statement

External Photo Charge

In order to evaluate and treat your condition, external photos may be required. Although insurance companies require proper documentation with photos, it may not be a covered service. A photo charge of $15.00 is due at the time of initial service. This charge is in addition to your office visit, copay or deductible. If you are covered by insurance, we will file for this charge for reimbursement. If we are reimbursed by your insurance company for this charge, your account will be credited back the fee.

I understand that Dr. Walrath/Woolfson Eye Institute may use photos for the treatment of my care. I understand that the charge may not be a covered service and that I am responsible for payment at the time of service.

______________________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 us promptly 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.

Signed: ____ Date: ____________________________________

Please Print Name: ____

Witnessed by staff member: ____ Date: __________________________________

Joseph Walrath, MD

Ophthalmic Plastic Surgery
800 Mt. Vernon Hwy NE, Ste. 125
Atlanta, GA 30328

770-804-1684 x 119
770-804-1684 x 166
jwalrath@woolfsoneye.com
www.josephwalrathmd.com

Federally Mandated Smoking Status and Vaccination Status Form

Patient Name: ______________________________

Date of Birth: ______________________________

Service Date: ______________________________

Do you smoke? Yes _____ No _____

Packs per day: __________

If over age 65, have you had the pneumonia vaccine?

Yes _____ No _____

Date of vaccination: _______________

Joseph Walrath, MD
Oculoplastic Surgery

800 Mt. Vernon Hwy., Atl., GA 30328
Ofc: 770.804.1694 / Fax:
770.255.1275

Ready to Quit Smoking: After Visit Care Instructions.

Cigarette smokers crave the nicotine in cigarettes. Giving it up is much harder than simply changing a habit. Your body has to stop craving the nicotine. It is hard to quit, but you can do it. There are many tools that people use to quit smoking. You may find that combining tools works best for you.

There are several steps to quitting. First you get ready to quit. Then you get support to help you. After that, you learn new skills and behaviors to become a nonsmoker. For many people, a necessary step is getting and using medicine.

Your doctor will help you set up the plan that best meets your needs. You may want to attend a smoking cessation program to help you quit smoking. When you choose a program, look for one that has proven success. Ask your doctor for ideas. You will greatly increase your chances of success if you take medicine as well as get counseling or join a cessation program.

Some of the changes you feel when you first quit tobacco are uncomfortable. Your body will miss the nicotine at first, and you may feel short-tempered and grumpy. You may have trouble sleeping or concentrating. Medicine can help you deal with these symptoms. You may struggle with changing your smoking habits and rituals. The last step is the tricky one: Be prepared for the smoking urge to continue for a time. This is a lot to deal with, but keep at it. You will feel better.

Follow-up care is a key part of your treatment and safety. Be sure to make and go to all appointments, and call your doctor if you are having problems. It's also a good idea to know your test results and keep a list of the medicines you take.

Where can you learn more?
Go to: www.smokefree.gov