

William P. Mack, M.D., P.A.

PLEASE PRINT

ACCOUNT NUMBER: _____

DATE: ____/____/____

PATIENT'S NAME: _____

HOME #: _____

CELL #: _____

PATIENT'S ADDRESS: _____
street city state zip

SECOND OR SUMMER ADDRESS: _____
street city state zip

EMAIL ADDRESS: _____

PATIENT'S AGE: _____ DATE OF BIRTH: ____/____/____ SOC. SEC. #: _____ - _____ - _____

MARTIAL STATUS: S M W D SEX: F M SPOUSE'S NAME: _____

PERSON RESPONSIBLE FOR BILL: _____ SPOUSE'S/PARENT'S SOC. SEC. #: _____ - _____ - _____

EMPLOYERS'S NAME AND ADDRESS: _____ PHONE: _____
OR FATHER'S (IF PATIENT IS A MINOR) EXT.: _____

SPOUSE'S EMPLOYER AND ADDRESS: _____ PHONE: _____
OR MOTHER'S (IF PATIENT IS A MINOR) EXT.: _____

REFERRED BY: _____ RELIGION: _____

MEDICAL HISTORY:

DO YOU HAVE?	HOW LONG?	DO YOU HAVE?	HOW LONG?
<input type="checkbox"/> YES <input type="checkbox"/> NO – HIGH BLOOD PRESSURE	_____	<input type="checkbox"/> YES <input type="checkbox"/> NO – CANCER	_____
<input type="checkbox"/> YES <input type="checkbox"/> NO – DIABETES	_____	<input type="checkbox"/> YES <input type="checkbox"/> NO – EMPHYSEMA/ASTHMA	_____
<input type="checkbox"/> YES <input type="checkbox"/> NO – HEART TROUBLE	_____	<input type="checkbox"/> YES <input type="checkbox"/> NO – ARTHRITIS	_____
<input type="checkbox"/> YES <input type="checkbox"/> NO – STROKE	_____	<input type="checkbox"/> YES <input type="checkbox"/> NO – THYROID PROB.	_____
<input type="checkbox"/> YES <input type="checkbox"/> NO – MIGRAINE HEADACHES	_____	<input type="checkbox"/> YES <input type="checkbox"/> NO – KIDNEY DIS.	_____
<input type="checkbox"/> YES <input type="checkbox"/> NO – CATARACTS	_____	<input type="checkbox"/> YES <input type="checkbox"/> NO – LIVER DIS.	_____
<input type="checkbox"/> YES <input type="checkbox"/> NO – GLAUCOMA	_____	<input type="checkbox"/> YES <input type="checkbox"/> NO – STOMACH ULCERS	_____
<input type="checkbox"/> YES <input type="checkbox"/> NO – OTHER EYE DISEASES	_____	<input type="checkbox"/> YES <input type="checkbox"/> NO – ALCOHOL/TOBACCO USE	_____

ANY OTHER MEDICAL PROBLEMS NOT LISTED ABOVE? _____

YES NO – DOES ANYONE IN YOUR FAMILY HAVE ANY OF THE ABOVE DISEASES? IF SO WHICH? _____

YES NO – HAVE YOU HAD ANY EYE SURGERY? IF SO, WHAT, WHEN, AND BY WHOM? _____

YES NO – DO YOU HAVE ANY DRUG ALLERGIES? IF SO, TO WHAT? _____

IF YOU WEAR GLASSES, WHEN WAS YOUR LAST CHANGE IN GLASSES? _____

WHEN WAS YOUR LAST EYE EXAMINATION? _____ BY WHOM? _____

WHAT SURGICAL OPERATIONS HAVE YOU HAD? _____

WHAT MEDICATIONS DO YOU TAKE, INCULDING EYE DROPS? _____

NAME OF FAMILY PHYSICIAN: _____ PHONE #: _____ CITY: _____

William P. Mack, M.D., P.A.

Please list the family members or other person, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations):

Please list the family members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY.

Name _____ Phone Number _____

Name _____ Phone Number _____

Please print the address of where you would like your billing statements and/or correspondence from our office to be sent if other than your home.

Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL".

YES _____ NO _____

Please print the telephone number where you want to receive calls about your appointments, lab and x-ray results, or other health care information if other than your home number.

I am fully aware that a cell phone is not a secure and private line.

Can confidential messages (i.e., appointment reminders) be left on your telephone answering machine or voicemail?

YES _____ NO _____

PATIENT NAME _____ (guardian if under 18)

PATIENT SIGNATURE _____ DATE _____

LIFETIME AUTHORIZATION

MEDICARE or INSURANCE CERTIFICATION FOR PAYMENT

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for the physician services to the physician or organization furnishing the services.

I request that this authorization also apply to any insurance other than Medicare. I also request that payment of authorized MEDIGAP/Supplemental benefits be made on my behalf to William P. Mack, M.D. for any services furnished me by William P. Mack, M.D. I authorize any holder of medical of medical information about me to release to MEDIGAP/Supplemental insurer any information needed to determine these benefits payable for related services.

INSURANCE DISCLAIMER:

Due to the many different kinds of insurance companies, you are required to know your insurance coverage. Payment for all services rendered are your responsibility. This also applies to you if you choose to use an out of network physician at our facility under your HMO/PPO plan.

**** I ALSO UNDERSTAND BY SIGNING, I AM GUARANTEEING PAYMENT OF THIS ACCOUNT (IF INSURANCE IS BILLED AND DOESN'T PAY AS WELL). FAILURE TO PAY ON THIS ACCOUNT WITHIN 120 DAYS WILL RESULT IN COLLECTIONS FEES APPLIED TO THIS ACCOUNT BALANCE, IF ANY.

Signed _____ Date _____

Print Name _____

Title of Relationship _____

Medigap/Supplemental Signature _____

If signed by other than beneficiary, state the reason patient was unable to sign.

William P. Mack, M.D., P.A.

ACKNOWLEDGMENT OF RECEIPT
OF NOTICE OF PRIVACY PRACTICES

By my signature below, I acknowledge that I have received
William P. Mack, M.D., P.A.'s Notice of Privacy Practices.

Name

Signature

Date

If acknowledgment could not be obtained from the patient, the reason must be
documented below.

William P. Mack, M.D., P.A

South Tampa Medical Center
508 S. Habana Ave., Ste #170
Tampa, FL 33609

Phone: 813-875-5437
Fax: 813-873-9373
www.mackmd.com

NOTICE OF PRIVACY PRACTICES

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

At William P. Mack, M.D., P.A., we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice. The law permits us to use or disclose your health information to those involved in your treatment. The following are examples.

1. Review of your file by a specialist doctor whom we may involve in your care.
2. We may use or disclose your health information for payment of your services. We may send a report of progress to your insurance company.
3. We may use or disclose your health information our normal healthcare operations. Such as our staff entering your information into our computer.
4. We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.
5. We may use your information to contact you. We may send newsletters or other information. We may also call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.
6. In an emergency, we may disclose your health information to a family member or another person responsible for your care.
7. We may release some or all of your health information when required by law.
8. If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization.

YOUR RIGHTS

1. You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.
2. You have the right to know of any use or disclosure we make with your health information beyond the above normal uses.
3. As we will need to contact you from time to time, we will use whatever address or telephone numbers you supply us with.
4. You have the right to see and receive a copy of your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.
5. You have a right to keep a copy of this notice.
6. If we change any of the details of this notice, we post a copy of the current policy with the effective date on the notice.
7. You may file a complaint with the Privacy Officer at this practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against for filing a complaint.

This notice goes into effect as of April 14, 2003.