William P. Mack, MD

PLEASE PRINT

ACCOUNT NUMBER: _____ DATE: _____/_____/_____

PATIENT'S NAME:_____ HOME#:_____

CELL #: _____

PATIENT'S ADDRESS:_____

Street City State ZIP

SECOND/ SUMMER ADDRESS: _____

Street City State ZIP

EMAIL ADDRESS:_____

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

MARITAL 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:_____

MEDICAL HISTORY:

DO YOU HAVE?		HOW LONG?	DO YOU HAVE?		HOW LONG?
YES	NO – HIGH BLOOD PRESSURE	_____	YES	NO - CANCER	_____
YES	NO- DIABETES	_____	YES	NO – EMPHYSEMA/ASTHMA	_____
YES	NO – HEART TROUBLE	_____	YES	NO – ARTHRITIS	_____
YES	NO – STROKE	_____	YES	NO – THYROID PROB.	_____
YES	NO – MIGRAINES	_____	YES	NO – KIDNEY DIS	_____
YES	NO- CATARACTS	_____	YES	NO – LIVER DIS	_____
YES	NO – GLAUCOMA	_____	YES	NO – STOMACH ULCERS	_____
YES	NO – OTHER EYE DISEASES	_____	YES	NO – ALCOHOL/TOBACCO USE	_____

ANY OTHER MEDICAL PROBLEMS NOT LISTED ABOVE? _____

_____

☐ YES ☐ NO – DOES ANYONE IN YOUR FAMILY HAVE ANY OF THE ABOVE DISEASES?

_____

☐ 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, PLEASE LIST REACTION TYPE?

_____

WHEN WAS YOUR LAST EYE EXAM?_____ GLASSES CHANGE? ____ BY WHOM? _____

WHAT SURGERIES HAVE YOU HAD?_____

_____

_____

WHAT MEDICATIONS DO YOU TAKE INCLUDING EYE DROPS AND OVER THE COUNTER MEDS?

_____

_____

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

PHARMACY: _____ PHONE#_____ STREET:_____ 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
****COSMETIC PATIENTS- SIGN ACKNOWLEDING PAYMENT OF SERVICES****

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

3109 W. Azeele Street
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.

William P. Mack, M.D.
3109 W. Azeele Street
Tampa, FL 33609
(813) 875-5437

Surgical Consent Form

Patient _____ Date _____ Time _____

1. I, the undersigned, hereby authorize William P. Mack, M.D. to perform the following procedure(s):
   _____
   AND OTHER RECONSTRUCTIVE PROCEDURES AS NEEDED.

2. I consent to the administration of anesthesia and to the use of such anesthetic agents as may be deemed necessary and advisable, with the exception of
   _____.

3. I consent that any tissue or parts surgically removed may be disposed of in accordance with accustomed practice.

4. I recognized that, during the course of the operation, unforeseen conditions may necessitate additional or different procedures than those set forth in the above procedure. I therefore further authorized and request that the above-named surgeon, his assistants, or his designees perform such procedures as are, in his professional judgment, necessary and desirable, including but not limited to, procedures involving pathology and radiology. The authority granted under this paragraph shall extend to remedying conditions that are not known to the above named at the time the operation is commenced.

5. The procedure as described above, its alternative and risks were explained to me by William P. Mack, M.D. I herby certify that I have read and fully understand the above consent. The above-named surgeon has explained the reason why the above surgery is considered necessary, its advantage and disadvantage and possible complications, if any, as well as possible alternative modes of treatment to me. I also certify that no guarantee or assurance has been made as to the results that may be obtained as a result of the surgery.

6. I authorize use of technical staff to assist, under Dr. Mack's supervision, in the closure of the skin in order to assist in the comfort of the patient.

Patient Signature _____ Witness _____

Date _____ Date _____

*****IF YOU DO NOT WISH TO AUTHORIZE PICTURE USE, PLEASE LEAVE BLANK*****

William P. Mack, M.D.
3109 W. Azeele Street
Tampa, FL 33609
(813) 875-5437 phone
(813) 873-9373 fax

Authorization for photographs/videotaping

I authorize my physician, William P. Mack, M.D., to take photographs pre-operative and post-operative and/or video tape or by other similar means record my surgery/procedure(s). I understand that reproduction or publication of said photographs and recordings will be used for the purpose of medical/scientific documentation, research, education, before and after surgical portfolios, commercials, websites, social media platforms including Facebook and Instagram, advertisements and/or medical record documentation for my medical record.

I understand that the photographs and recorded material may include appropriate portions of the body to demonstrate surgery/procedure(s) and that every effort will be made to protect the patient's identity in those materials.

_____ _____
Patient Name (Print) Date of Birth

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date