Eye Consults by Sandy Thimmappa Cohen MD

Informed Consent for Medical Record Review/Authorization for Payment

NAME: _____

DATE OF BIRTH: _____

Email: _____ (summary of consultation will be sent via secure email)

Address _____

City State Zip code

Phone number:

List of Medical Problems:

List of Eye Problems and Eye Surgery (date):

List of Eye Drops and Medications (pills)

Allergies:

What questions do you have about your medical record or treatment?

1)_____

2)_____

3)_____

4) _____

5)_____

Expected Benefits:

- Improved access to medical care by enabling a patient to remain in his/her location while the healthcare provider provides medical information from a distant site

- Ability to obtain a record review from a distant medical specialist without traveling

Possible Risks:

As with any medical procedure, there are risks associated. These risks include, but may not be limited to:

- Information transmitted may not be sufficient to allow for complete and appropriate medical opinions. For instance, most parameters of the eye examination cannot be tested remotely, so consultation will be based on medical records submitted. In addition, there may be poor resolution of images on copies of records. This may cause a delay or incomplete medical opinion.

- Security protocols could fail, causing a breach of privacy of personal medical information.

Policy:

- Eye consults prohibits unauthorized recordings of these medical record review consultations. If recordings are wanted please contact our staff and we can accommodate this request after appropriate paperwork has been signed. Anyone who violates this policy will be dismissed as a client of Eye Consults PLLC.

By signing this form, I understand that:

- The laws that protect privacy and the confidentiality of medical information also apply to the review of my medical records and that no information obtained in the record review will be disclosed to other entities without my consent.
- I understand that no results can be guaranteed or assured.
- I understand I will be billed for the medical chart review on my credit card

Consent. By signing below, you consent (agree) that:

- I have read this informed consent form and all my questions has been answered.
- I am requesting my medical records be reviewed for a 2nd opinion.
- I understand the information in this informed consent form and all of my questions have been answered.
- Please keep a copy for this consent and copy of your medical records (we do not send back medical records)
- Please note this service is only offered for records up to 10 pages for a one consultation setting

I hereby authorize _____(print your name) Sandy Thimmappa Cohen MD Eye Consults PLLC to evaluate my medical records to help answer my questions about my diagnosis and treatment. I also agree to policies outlined in this consent.

_____

Signature Date

Credit Card Authorization Form

Please complete all fields. This authorization is for a one time charge

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ AMEX
Cardholder Name (as shown on card): _____
Card Number: _____
Expiration Date (mm/yy): _____
Cardholder ZIP Code (from credit card billing address): _____

I,_____, authorize Eye Consults (Sandy Thimmappa Cohen MD) to charge my credit card above for $200.00 (Two hundred dollars) for a one time medical chart review.

_____ _____

Customer Signature Date