Annapolis Eye Consultants (Misty L. Wray, M.D.)

127 Lubrano Drive, Suite 102

Annapolis, MD 21401

Phone: (443) 221-7775 | Fax: (443) 714-8120

www.EyeAnnapolis.com

 ***IMPORTANT INFORMATION ABOUT YOUR EYE EXAM***

**YOUR FIRST VISIT**

Your first appointment with our practice could take 1 ½ to 2 hours depending on your specific problem and/or needs. Dilation of your eyes may be required.

**WHAT TO BRING TO YOUR APPOINTMENT**

Please bring up-to-date insurance cards, driver’s license, referral (if applicable), eyeglasses, sunglasses, eye medications/drops, and a complete list of ALL your medications and the dosage.

**ROUTINE VISION PLAN VS. MEDICAL PLAN**

Please inform the front desk at the time of check-in if you have a vision plan (Block/Superior Vision, etc.) We participate with many medical plans and some vision plans. Medical plans cover medical eye problems such as (but not limited to) dry eye, eye allergies, cataracts, and glaucoma. Medical plans do not cover the cost of glasses or routine eye care, such as the refraction (vision exam) for glasses. Vision plans only cover routine eye care/routine refractions for eyeglasses.

**IF YOU WANT TO UPDATE YOUR EYEGLASS PRESCRIPTION**

**Please inform us at the beginning of your exam if you would like to update your eyeglass prescription or if you feel as if there might be a change in your vision. *Note: we do not fit for contact lenses in our office.*** Once the dilating drops are placed in your eyes, your vision will become blurred and it will be too late to perform a refraction. A refraction determines not only your most accurate eyeglass prescription, but also the best possible vision. **\*\*\*Refractions are not covered by Medicare and most other medical insurance plans. Because Annapolis Eye Consultants know this fee is an out of pocket expense the office has reduced the price to $45.00. If your prescription is a complicated one the fee may be $65.00\*\*\***

**IF YOU WISH TO HAVE YOUR EYES DILATED**

Dilation is usually performed as part of the full medical eye examination. Dilation is typically performed toward the end of the exam. Adequate pupillary dilation usually takes between 15-30 minutes. After being dilated, you may experience significant light sensitivity and blurred vision for 2-4 hours. The duration and severity of these side effects differ from person to person. If you have any doubts about driving while dilated, we recommend bringing a driver or declining dilation.

**FINANCIAL POLICY**

Thank you for choosing Dr. Wray as your ophthalmology provider! Our entire staff is committed to providing you with the best possible care. Your full understanding of our financial policy is a very important part of our professional relationship. Please review the following in its entirety and sign prior to your visit.

**Fees and Payments**

Fees are standardized and based on the complexity of your visit and/or procedure(s). Co-payments, non-covered charges, and any outstanding balances are required at the time of service. We accept cash, personal checks, and most major credit/debit cards. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are ultimately the patient’s responsibility from the date the services are rendered. ***For an insurance claim to be filed, you must present a current insurance card.*** Co-insurance, co-payments, and deductibles are determined by your insurance carrier and are reported to us on your explanation of benefits. Once we are notified, we will add the appropriate charge to your account and send you a statement. **This charge is payable upon receipt of the statement.**

**Insurance**

Your insurance coverage is a contract between you, your employer (if applicable), and the insurance company(s)—we are not a part of that contract. Before your visit, please contact your insurance company to verify that Dr. Misty Lee Wray’s practice at the above location participates with your plan and that the services you intend to receive are covered. Not all services are a covered benefit so it is very important that you understand the provisions of your individual policy. **Reduction or rejection of your claim by your insurance company does not relieve you of your financial obligation to Misty Lee Wray, M.D.** If your insurance company has not paid a claim on your behalf within 90 days, the balance could become your responsibility.

**Cancellation/Missed Appointments**

Your appointment time has been set aside for you, making it unavailable to other patients. **For all missed or canceled appointments with less than 24 hours’ notice, you will be charged a $40 fee**. Appointment reminder calls are a courtesy. Should you not receive a reminder call, it is still YOUR responsibility to remember your appointment.

***Excessive no shows may be grounds for your dismissal from the practice.***

**Non-Payment of Outstanding Accounts**

Accounts that are not paid within 120 days will be sent to an external collection agency. In addition to your outstanding balance, you will be responsible for a collection fee equal to 30% of the balance that is turned over to collections. You will be responsible for any other fees we incur from the external collection agency while attempting to collect your balance.

**Returned Check Charge**

Non-Sufficient Funds (NSF) checks and any other checks returned to us by your bank are subject to a $30 fee.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**PATIENT REGISTRATION FORM** **How did you hear about us?** (check all that apply)

***Please print clearly and complete all sections.*** Friend \_\_\_\_\_\_ Internet \_\_\_\_\_\_

 Relative \_\_\_\_\_ Insurance \_\_\_\_\_\_

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M.I. \_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: Male / Female

S.S.N. (for Billing/Patient Portal): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status: Single Married Divorced Separated Widowed

Race: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ethnicity (circle one): Hispanic / Non-Hispanic Preferred Language: \_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Street

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 City State Zip Code

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referring Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Vision Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Note: We do not accept most vision plans.

I authorize Misty Lee Wray, M.D. to apply for benefits on my behalf for services rendered. I request payment from my insurance company to be made directly to the physician. I certify that the information I have reported regarding my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claims. I permit a copy of this authorization to be used in place of the original. I may revoke this authorization at any time in writing. I understand that nothing herein relieves me of the primary responsibility and obligation to pay for medical services provided.

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**Health History/Review of Systems**

NAME: \_\_\_ \_\_\_\_\_\_\_\_\_\_\_ AGE: \_\_\_\_\_\_\_\_\_\_\_\_\_

**Personal Medical History - Have you ever experienced any of the following conditions:**

Arthritis (other than back) Yes No Graves’ Disease Yes No

Cancer Yes No Heart Disease Yes No

Diabetes Yes No Hypertension Yes No

Fever Blisters Yes No Lupus Yes No

Glaucoma Yes No Thyroid Yes No

**Details for “Yes” responses from above and/or other medical conditions:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Operations (including eye surgery) Year**  **Social History**

 \_\_ \_ \_\_\_\_\_\_\_\_ Marital Status: M S Sep W D

 \_ \_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_ \_ \_\_\_\_\_\_\_\_ Smoker: Yes Never Former Smoker: years ago

 \_\_\_\_\_\_\_ \_ \_\_\_\_\_\_\_\_ Alcohol: Yes No Drinks per day: \_\_\_\_\_\_\_\_

 Drug Use: Yes No Name/Frequency: \_\_\_\_\_\_\_\_\_

**Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Latex: Yes No Medication Allergies: Yes No If Yes, please list below and specify reaction

**Medication Allergies:**

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Medications:** (if you brought a separate list of medications, please give to the front desk to make a copy)

|  |  |  |  |
| --- | --- | --- | --- |
| **Medications** |  **Dose** | **Frequency** | **Reason** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

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**Review of Health Systems**

**Eyes Respiratory Blood/Lymph Nodes\_\_\_**

Previous Surgery Yes No Cough Yes No Easy Bruising Yes No

Contact Lens Yes No Congestion Yes No Gums Bleed Easily Yes No

Pain Yes No Wheezing Yes No Prolonged Bleeding Yes No

Double Vision Yes No Asthma Yes No Heavy Aspirin Use Yes No

Glaucoma Yes No

Cataracts Yes No **Gastrointestinal\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Musculoskeletal\_\_\_\_\_\_**

Macular Degeneration Yes No Heartburn Yes No Stiffness Yes No

Dry Eyes Yes No Nausea/Vomiting Yes No Arthritis Yes No

Flashes Yes No Jaundice/Hepatitis Yes No Joint Pain/Swelling Yes No

Floaters Yes No

**Ear, Nose, and Throat Genitourinary \_ \_\_\_\_\_ Skin\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Hard of Hearing Yes No Pain/Difficulty Yes No Rash/Sores Yes No

Ringing in Ears Yes No Blood Urine Yes No Lesions Yes No

Vertigo Yes No History of Kidney Stones Yes No Hives/Eczema Yes No

 History of STDs Yes No

**Cardiovascular\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Psychiatric\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Neurological\_\_\_\_\_\_\_\_\_**

Chest Pain Yes No Anxiety/Depression Yes No Seizures Yes No

Dizziness Yes No Mood Swings Yes No Weakness/Paralysis Yes No

Fainting Spells Yes No Difficulty Sleeping Yes No Numbness Yes No Shortness of Breath Yes No History of Kidney Stones Yes No Tremors Yes No Irregular Heartbeat Yes No **of Kidney Stones** Yes No

Difficulty Lying Flat Yes No **Endocrine\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ of** **Immunologic \_\_\_\_\_\_** No Tremors Increased Thirst Yes No Hives Yes No

**Constitutional\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Increased Hunger Yes No Itching Yes No

Fatigue/Weakness Yes No Increased Urination Yes No Runny Nose Yes No

Fever Yes No Increased Sweating Yes No Sinus Pressure Yes No

Weight Gain/Loss Yes No Fingernail Changes Yes No Tremors Yes No of Kidney Stones

If Yes, please explain: \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History** (Please indicate relation, i.e., father, mother, grandfather, grandmother, sibling, children)

|  |  |  |  |
| --- | --- | --- | --- |
| **Disease** | **Relation** | **Living or Deceased** | **Approximate Age** |
| Cancer |  |  |  |
| Diabetes |  |  |  |
| Heart Disease |  |  |  |
| Hypertension |  |  |  |
| Thyroid |  |  |  |
| Macular Degeneration |  |  |  |
| Retinal Detachment |  |  |  |
| Droopy Eyelids |  |  |  |
| Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |

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**AUTHORIZATION TO RECEIVE/RELEASE HEALTH INFORMATION**

Due to **the HIPAA Compliance Privacy Laws of the Federal Government**, it is mandatory that we ask you to review and answer the following questions.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May we leave messages containing medical information at the following?

Home Phone: Yes No Cell Phone: Yes No Email: Yes No

May we contact you at your place of employment? Yes No

If so, may we leave a voicemail? Yes No

Are there any person(s) or family member(s) that you authorize to receive and discuss information regarding your personal health information (including general information, surgical, and billing)? **Included would be anyone you would list as an emergency contact that could call on your behalf if you needed them to.**

 Yes No If yes, please provide the following:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alternate Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this person your Power of Attorney for medical purposes? Yes No

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alternate Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize Dr. Misty Lee Wray to obtain or release all pertinent information regarding my medical care, as needed, to assist in my ongoing treatment to or from healthcare providers, laboratories, radiology facilities, or other institutions. **This authorization remains in effect until revoked**.

I have reviewed the information and provide my consent regarding all issues as stated above.

I have reviewed Dr. Misty Lee Wray’s Notice of HIPAA Privacy Policy. A copy of this policy will be provided to me upon request.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WITNESSED BY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Medical Records Release**

PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PREFERRED PHONE NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Previous Eyecare Provider**

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ LOCATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FAX NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Care Physician**

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ LOCATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FAX NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If there are any additional healthcare providers you would like our office to obtain records from, please include their information below:**

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ LOCATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FAX NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize you to release to Misty Lee Wray, M.D. a copy of my medical records to be used for continuing medical care. I reserve the right to revoke this authorization in writing at any time. Further, I understand that this Protected Health Information may be re-disclosed by the recipient and, thus, no longer protected under privacy rules.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient or Guarantor Signature Date

**Healthcare Providers: Please copy and send requested records to Dr. Wray.**

Misty Lee Wray, M.D.

127 Lubrano Drive, Suite 102

Annapolis, MD 21401

Or FAX to: (443) 714-8120