# AUSTIN OCULOFACIAL PLASTICS
COSMETIC AND RECONSTRUCTIVE SURGERY

## PATIENT INFORMATION

| Patient's Last name: | First name: | Middle: | Marital status: |
|---|---|---|---|
| | | | |

| Is this your legal name? | If not, what is your legal name? | Former name: | Birth date: / / | Age: | Sex: ○ M ○ F |
|---|---|---|---|---|---|
| | | | | | |

Address: City: State: Zip:

| Social Security no.: | Home phone no.: | Cell phone no.: |
|---|---|---|
| | | |

Email Address: How would you like to hear from us? ☐ Phone ☐ Email

What types of email communication do you wish to receive? ☐ Appointment Reminders ☐ Company Specials ☐ Newsletters ☐ All Communications

Chose clinic because/referred to clinic by (Please choose one option):

Dr._____ Family Friend Hospital Insurance Plan Other

## INSURANCE INFORMATION

Please fill out insurance information entirely. In addition, please give your insurance card to the receptionist.

| **Name of Primary Insurance:** Subscriber's Name: | Birth Date: / / | ID Number: | Group No.: |
|---|---|---|---|
| | | | |

| **Name of Secondary Insurance:** Subscriber's Name: | Birth Date: / / | ID Number: | Group No.: |
|---|---|---|---|
| | | | |

## IN CASE OF EMERGENCY

| Name of local friend or relative: | Relationship to patient: | Home phone no.: | Cell phone no.: |
|---|---|---|---|
| | | | |

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Dr. Sean Paul. I understand that I am financially responsible for any balance. I also authorize Austin Oculofacial Plastics or my insurance company to release a ny information required to process my claims.

Patient/Guardian signature _____ Date _____

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# MEDICAL HISTORY FORM

NAME_____ AGE_____ DOB_____ Ht_____ Wt_____ Date_____

REASON FOR TODAY'S VISIT_____

**Drug ALLERGIES:** YES / NO **Drug Allergy Name(s):**
**Latex ALLERGY:** YES / NO

**MEDICATIONS** (Include all ocular and over-the-counter medications, vitamins, and herbal supplements)

1._____ 4._____ 7._____

2._____ 5._____ 8._____

3._____ 6._____ 9._____

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ARE YOU UNDER THE CARE OF A PAIN MANAGEMENT DOCTOR? YES / NO

**OCULAR HISTORY** ☐ None

Select any that apply below:

- ☐ Anophthalmia (lost an eye) Right Left
- ☐ Amblyopia (lazy eye) Right Left
- ☐ ARMD (muscular degeneration) Right Left
- ☐ Cataracts Right Left
- ☐ Glaucoma Right Left
- ☐ GRAVES (thyroid eye disease) Right Left
- ☐ Retinal detachment Right Left
- ☐ Strabismus (crossed eyes) Right Left

**MEDICAL HISTORY** ☐ None

- ☐ Arthritis
- ☐ Asthma
- ☐ Liver Disease (hepatitis)- Type:_____
- ☐ High Blood Pressure (hypertension)
- ☐ Cancer- Type:_____
  treatment / chemo / radiation / surgery
- ☐ Irregular Heart Rhythm (atrial fib, heart block)
- ☐ Lung Disease (emphysema / COPD)
- ☐ Require continuous oxygen
- ☐ HIV
- ☐ Diabetes- Type:_____
- ☐ Gastroesophageal Reflux Disease (GERD)
- ☐ Obstructive Sleep Apnea ☐ Require CPAP
- ☐ Heart Disease- Type:_____
- ☐ Heart Failure (Congestive Heart Failure)
- ☐ Stroke- Date:_____
- ☐ Kidney Disease
- ☐ Thyroid Disease- Type:_____
- ☐ Other:_____

**OCULAR SURGERY / OTHER SURGICAL HISTORY** ☐ None

- ☐ Eyelid surgery- Type:_____
- ☐ Facelift
- ☐ Nose surgery- Type:_____
- ☐ Cataract surgery: Right Left
- ☐ LASIK refractive surgery
- ☐ Glaucoma surgery: Right Left
- ☐ Coronary artery bypass- Date:_____
- ☐ Cardiac pacemaker/defibrillator
  Date last checked:_____
- ☐ Cardiac stent placement- Date:_____

**FAMILY HISTORY** ☐ None

☐ Anesthesia complications
☐ Bleeding disorders
☐ Diabetes- Type: _____
☐ Heart Disease- Type: _____
☐ High blood pressure (hypertension)
☐ Thyroid Disease- Type: _____
☐ Cancer- Type: _____

**SOCIAL HISTORY** ☐ None

*Alcohol use?*
☐ YES ☐ NO Frequency: ☐ daily ☐ weekly ☐ rarely

*Recreational drug use?*
☐ YES ☐ NO Type: _____

**SMOKER STATUS** ☐ N/A

☐ Current, every day smoker ☐ Never smoker ☐ Current, sometimes smoker

**PHARMACY** (Location you would like us to call in any medications prescribed)

Pharmacy _____ Address _____

Telephone _____ City/State _____

**PHYSICIANS**

***Referring Doctor***

Pharmacy _____ Address _____

Telephone _____ City/State _____

***Primary Care Physician***

Pharmacy _____ Address _____

Telephone _____ City/State _____

***Cardiologist***

Pharmacy _____ Address _____

Telephone _____ City/State _____

## CONSENT TO PHOTOGRAPHY

I hereby authorize photographs to be taken for medical purposes. I agree to the use of the negative, prints, copies or reproductions for insurance documentation, teaching and for monitoring my condition.

_____

Signature of Patient Date

I hereby grant permission to use my photographs/videos for social media purposes. I understand that the negatives, prints, copies or reproductions will be posted on any or all AOP websites, social media sites, etc. for the purpose of sharing my procedure results.

_____

Signature of Patient Date

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# FREQUENTLY ASKED QUESTIONS REGARDING HIPAA

In a constantly changing healthcare environment, **AUSTIN OCULOFACIAL PLASTICS** is committed to educating their patients about healthcare issues that affect them. As a result, they have provided general information about the Health Insurance Portability and Accountability (HIPAA) of 1996 for your review. **AUSTIN OCULOFACIAL PLASTICS** is complying with HIPAA regulations and will be happy to answer any additional questions you might have.

**WHAT IS THE PRIVACY RULE?**
The Privacy Rule is part of the HIPAA regulation of 1996. The Privacy Rule establishes a federal requirement that doctors, hospitals or other healthcare providers and health plans obtain a patient's written consent before using or disclosing a patient's personal information to carry out treatment, payment or healthcare operations.

**WHAT IS PROTECTED HEALTH INFORMATION (PHI)?**
Protected Health Information (PHI) means any personal health information as defined by law, including demographic information collected by healthcare provider or other entity that could potentially identify the individual. PHI includes all medical records and other individual's identifiable health information held or disclosed by AUSTIN OCULOFACIAL PLASTICS regardless of how it is communicated (e.g. electronically, written verbally).

**WHAT IS TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS (TPO)?**
TPO refers to the treatment, payment or healthcare operations of AUSTIN OCULOFACIAL PLASTICS. In other words, quality patients care; ensure that the physician is paid for services; and, operate the business. Some examples of these activities are use of PHI by the physician and clinical staff to treat a patient use; use of PHI by administrative staff for strategic planning and internal management activities.

**WHY DO I HAVE TO SIGN A CONSENT FORM?**
In order to use or disclose your PHI, AUSTIN OCULOFACIAL PLASTICS is required to obtain a signed consent form from you to directly treat you or carry out healthcare payment and business related activities. AUSTIN OCULOFACIAL PLASTICS is not required by law to treat you, or when there are substantial communication barriers. AUSTIN OCULOFACIAL PLASTICS reserves the right to refuse to treat you if you do not sign the consent form.

**WHAT IS THE DIFFERNCE BETWEEN CONSENT AND AUTHORIZATION FORMS?**
In order to use or disclose your PHI for specific purpose, other than direct treatment, payment, or healthcare operations, AUSTIN OCULOFACIAL PLASTICS is required to obtain a signed authorization form from you. For example, if you request AUSTIN OCULOFACIAL PLASTICS to disclose PHI to a third party, you must an authorization form. This authorization form is more detailed than a consent form and has a specific expiration date.

## PATIENT RECEIPT OF "NOTICE OF PRIVACY PRACTICES"

**AUSTIN OCULOFACIAL PLASTICS** has provided information regarding the **NOTICE OF PRIVACY PRACTICES**. This notice describes the practice's commitment to privacy, my rights to privacy and how **AUSTIN OCULOFACIAL PLASTICS** may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations.

By signing this form, I am acknowledging that I have reviewed the Notice of Privacy Practices which explains how my medical and personal information will be used and disclosed. I understand that I am entitled to receive a copy of this document upon request.

_____
Patient Name (Printed)

_____
Signature of Patient/Personal Representative Date

_____
Relationship to Patient

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# GENERAL OFFICE AND FINANCIAL POLICIES

Name (*please print*):_____Date_____

In compliance with the Federal Consumer Protection Act, **AUSTIN OCULOFACIAL PLASTICS** is furnishing you with information regarding your financial responsibilities.

Due to federal law, a **VALID IDENTIFICATION** (driver's license, ID card, passport, military ID) and **CURRENT INSURANCE CARD** must be presented at **EVERY OFFICE VISIT**. These measures have been enacted to protect you from insurance fraud and identity theft.

**Any applicable deductibles and co-payment are due at the time services are rendered**. ***It is always your responsibility to understand the coverage of your insurance policy and its referral/authorization process.***
Please understand that our office cannot accept responsibility for payment/non-payment on your insurance claims. Questions about coverage and benefits should be directed to your insurance company.

**BILLING AND COLLECTION POLICY**
Any invoices received from our office are due immediately upon receipt. If for any reason you cannot pay the bill in full, we ask that you contact our billing office to set up a payment plan. If you fail to respond to the bill or fail to cooperate with the terms of your payment plan, your account may be turned over to an outside agency for resolution. If this occurs, you agree to be legally responsible for any and all collection fees. To avoid problems due to delayed mail, it is your responsibility to notify our office of any changes in name, address, phone numbers or insurance coverage.

**CREDIT POLICY**
We do not offer in-house payment plans for deductibles. All deductibles must be paid in full at the time of service. We accept cash, check, Visa, Mastercard, and American Express. Alternative forms of credit that we accept are Care Credit and Alphaeon. There is a $35 fee for any returned check.

**CANCELLATION / MISSED APPOINTMENTS POLICY**
If you are unable to keep your scheduled appointment, please give our office a minimum of 24 hours' notice so we can accommodate another patient in your time slot. If you fail to do so, a no-show fee may be applied accordingly ($50 for new patients and $25 for return/follow-up patients).

**MEDICAL RECORDS AND FORMS**
A form to request transfer of your medical records to our clinic is available on our website. To send your records from our c linic to another physician, we need a written request from you. If forms are sent or dropped off at our office to be completed on y our behalf you should allow 7 days for completion of any forms.

**PRESCRIPTION REFILLS AND PREAUTHORIZATIONS**
Prescriptions are typically given at office visits with enough refills to last until your next follow-up visit. In the event that a refill is needed sooner, you should contact your pharmacy so the refill can be requested electronically. Please allow 24 hours for all prescription refill requests.

**CONTROLLED SUBSTANCE POLICY**
Controlled substances include narcotic pain medications, some anti-anxiety medications, attention-deficit medications and some sleep medications. These medications can be habit-forming if misused and extremely dangerous/lethal when combined with certain other medications.

The physicians at Austin Oculofacial Plastics ***do not prescribe chronic pain medications***. If your condition warrants repeated use of pain medications, you will be referred to a Pain Management Specialist.

**Signature of Patient** _____ Date:_____

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## AUTHORIZATION FOR RELEASE OF INFORMATION

**Records requested:**

- ❑ Records of care from _____ to _____
- ❑ Most recent office notes & labs
- ❑ Other (please specify) _____

**Reason for release:**

- ❑ Surgery
- ❑ Change of physician or patient moving
- ❑ Other (please specify) _____

**Records Requested from.**

Primary Care Physician
Name: _____ Phone: _____
Fax: _____

Cardiologist Phone:
Name: _____ Phone: _____
Fax: _____

Other
Name: _____ Phone: _____
Fax: _____

I, the undersigned, do hereby authorize the release of information described above from my medical records. I understand that reports may include information on drug/alcohol/psychological or communicable disease treatment. I understand that I may revoke this consent in writing at any time except to the extent that action has already been taken in reliance on it. A photocopy of this consent shall be considered valid.

Patient's Full Name (Please Print): _____ Date of Birth: _____
**Patient's Signature** _____ Date: _____

## AUTHORIZATION FOR RELEASE OF INFORMATION TO DESIGNATED PARTY

This Authorization grants permission to the Designated party(ies) named below to: have access to x-ray, laboratory; have access to telephone communication; be made aware of diagnosis, prognosis and treatment plans; have access to my financial and medical records.

I hereby authorize Austin Oculofacial Plastics to use and disclose my individually identifiable health information as described above. I understand that once this information is released to the Designated Party(ies) named be low, the released information may no longer be protected by federal privacy regulations.

Patient Name: _____ Date of Birth: _____

Designated Party: _____ Relationship to Patient: _____

**Patient's Signature** _____ Date: _____