OCULUS PLASTIC SURGERY

TODAY'S DATE ________

Patient's Name ____
Last First Middle

Address ____
Street & Apt # City State Zip

Home Phone ____________ Cell Phone ____________ Work Phone ____________

Any restrictions for contacting you? ❐ No ❐ Yes ____________

E-mail ____

Age ______ Birthdate ____________ SS# ____________ Sex ❐ Female ❐ Male

Marital Status ❐ Single ❐ Married to: ____________ ❐ Other: ____________

Responsible Party Name ____________ DOB ____________

Patient's Employer ____________ **Occupation** ____________

Emergency Contact
(Not in your household) ____________ Relationship to Patient ____________

Home Phone ____________ Work Phone ____________ Other Phone ____________

Address ____
Street & Apt # City State Zip

Primary Health Insurance Company ____________________________

Policy # ____________ Group # ____________ Ins. Phone ____________

Insured: Name ____________ DOB ____________ SS # ____________

Secondary Health Insurance Company ____________________________

Policy # ____________ Group # ____________ Ins. Phone ____________

Insured: Name ____________ DOB ____________ SS # ____________

OFFICE USE ONLY

			Referring Doctor

REFERRING PHYSICIAN INFORMATION ____________________________

REFERRING PHYSICIAN NAME____
ADDRESS____
CITY______________________STATE________ZIP CODE______________________
TELEPHONE # (   )______________________FAX # (   )______________________

PRIMARY CARE PHYSICIAN/OTHER PHYSICIANS____________________________

PRIMARY PHYSICIAN NAME____
ADDRESS____
CITY______________________STATE________ZIP CODE______________________
TELEPHONE # (   )______________________FAX # (   )______________________

Pharmacy Name____
ADDRESS____
CITY______________________STATE________ZIP CODE______________________
TELEPHONE # (   )______________________FAX # (   )______________________

Oculus Plastic Surgery ● Health Information
Specialty Surgery Center, Inc. ● Pre-Operative Anesthesia Evaluation

Patient Name:____________________ Age:________ Height:________ Weight:_____

Latex sensitivity: □ Yes □ No   Latex allergy: □ Yes □ No
Allergies to medication: □ None □ PCN □ Sulfa □ Codeine □ Iodine □ Other:____________________
____

Reaction:____

YES	NO	
		Anesthesia problems: □patient □family member □nausea □MH Describe:
		CNS: □ seizure □ stroke □ spinal cord injury □ muscle weakness □ migraines □ dementia □ other:
		High blood pressure
		Heart problems: □ chest pain □ ♥ attack □ ♥ murmur □ mitral valve prolapse □ pacemaker □ other:
		Bleeding problems: □ sickle cell □ transfusion □ anemia □ other:
		Breathing problems: □ Bronchitis □ emphysema □ asthma □ other:
		Smoke Tobacco: _____pack / day x_____years quit:
		Alcohol beverages:
		Diet pills/recreational drugs:
		Diabetes: □ diet controlled □ insulin dependent
		Glaucoma
		Thyroid problems: □ hypo □ hyper
		Liver problems: □ cirrhosis □ jaundice □ hepatitis □ other:
		Renal disease
		GI: □hiatal hernia □ acid reflux □ ulcers □ rectal bleeding □ other:
		Infections: □tuberculosis □ HIV □ other:
		Are you under the care of a psychiatrist?
		Do you have? □ dentures □ partials □ caps □ bonding □ loose or chipped teeth
		Limitations/devices: □ glasses □ contact lenses □ hearing aid □ mobility □ cognitive
		Other:
		Last menstrual period: ________ □ Not applicable □ post hysterectomy □ post menopausal

PREVIOUS SURGERIES AND APPROXIMATE DATE:

____

CURRENT MEDICATIONS (including aspirin and supplements): HOW OFTEN:

PATIENT SIGNATURE ____ DATE _____________

OCULUS PLASTIC SURGERY AND SPECIALTY SURGERY CENTER, INC.
PATIENT ACKNOWLEDGEMENT AND UNDERSTANDING OF "PRIVACY PRACTICES"

PATIENT'S NAME: ____
LAST FIRST MIDDLE

DOB: ________________

I understand that the patient's health information is private and confidential.

I understand that **Atlanta Oculoplastic and Cosmetic Surgery, P.C., DBA: Oculus Plastic Surgery and Specialty Surgery Center, Inc.** (separate entities) work very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand that Oculus Plastic Surgery / Specialty Surgery Center, Inc. may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations. In general, there will be no other uses and disclosures of the information unless I permit it. I understand that sometimes the law may require release of this information without my permission. These situations are very unusual. One example would be if a patient threatened to hurt someone.

Oculus Plastic Surgery / Specialty Surgery Center, Inc. have a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting the patient's privacy. I understand that I have the right to read this "notice" before signing this acknowledgement.

Oculus Plastic Surgery / Specialty Surgery Center, Inc. may update this acknowledgment and "Notice of Privacy Practices". If I ask, Oculus Plastic Surgery / Specialty Surgery Center, Inc. will provide me with the most current "Notice of Privacy Practices".

Within the "Notice of Privacy Practices" is contained a complete description of my privacy / confidentiality rights. These rights include, but are not limited to, access to my medical records, restrictions on certain uses, receiving an accounting of disclosures as required by law, and requesting communication by specified methods.

Oculus Plastic Surgery / Specialty Surgery Center, Inc. have established procedures, which help them meet their obligations to patients. These procedures may include other signature requirements, written acknowledgements, authorizations, reasonable time frames for requesting information, charges for copies, and non-routine information. I will assist Oculus Plastic Surgery / Specialty Surgery Center, Inc. by following these procedures if I choose to exercise any of my rights described in the "Notice of Privacy Practices".

My signature indicates that I have been given the chance to review a current copy of Oculus Plastic Surgery / Specialty Surgery Center, Inc.'s "Notice of Privacy Practices."

________________________________ ____________
Signature of Patient Date

____
Please Print Name

________________________________ ____________ ____________________
Signature if other than parent Date Relationship

FINANCIAL POLICY & INSURANCE AGREEMENT

OCULUS PLASTIC SURGERY

SPECIALTY SURGERY CENTER, INC.

1. I agree to furnish Atlanta Oculoplastic Surgery, P.C. / Oculus Plastic Surgery / Specialty Surgery Center, Inc. with a copy of my current health insurance card(s). I also agree to provide explanation of benefits and/or claim forms from my insurance company, when applicable.

2. I authorize the release of medical information necessary to process my insurance claim and I assign insurance benefits to Atlanta Oculoplastic Surgery, P.C. / Oculus Plastic Surgery / Specialty Surgery Center Inc. for services provided to me by ___Harvey "Chip" Cole, III, MD ___ Brent A. Murphy, MD ___ John P. Connors, MD (please check one)

3. I understand that co-pays are due at the time of service, as required by my insurance company.

4. I agree that I will be responsible for balances applied to my responsibility which are not covered by my health insurance plan.

5. In the event my account is turned over to an outside collection agency, I agree that I will be responsible for a fee of $25 by Atlanta Oculoplastic Surgery, P.C. / Oculus Plastic Surgery and/or Specialty Surgery Center, Inc. as well as any and all attorney fees, court costs, etc.

6. I understand that my account will be charged $25 when a check I presented for payment is returned marked "Non-sufficient Funds" (NSF). Returned checks over $500 will be assessed a fee of 5% of the amount of the check.

7. I understand that Atlanta Oculoplastic Surgery, P.C. / Oculus Plastic Surgery / Specialty Surgery Center, Inc. will bill my health insurance company and refund any overpayment on my account to the appropriate party (insurance company, patient).

8. I understand Atlanta Oculoplastic Surgery P.C. / Oculus Plastic Surgery / Specialty Surgery Center, Inc. allows 30 days for the processing of my claim by the insurance company. In the event the practice does not receive reimbursement within 45 days, they will contact my insurance company regarding the claim; I will be notified if they do not receive a response.

9. I will notify an Insurance Specialist at the practice if I am aware of a payment delay by my insurance company. It is my understanding the Insurance Specialists at the practice will provide me with assistance in resolving the claim.

10. Any co-insurance, deductible, out-of-pocket, and co-pay amounts will be my responsibility. In the event I am unable to pay my responsibility in full, I will contact the Insurance Specialists to discuss financial arrangements.

11. Medicare Patients Only – Medicare Signature on File - I request that payment of authorized Medicare benefits be made on my behalf to the provider for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature ____ Date ______________

I have read, understand and agree to the insurance assignment and financial policies stated above. I also agree that I have had the opportunity to discuss any questions or concerns regarding the above with one of the Insurance Specialists at the practice.

______________________________ ________________________

Signature of Patient Date

______________________________ ________________________

Please Print Name Social Security Number