SURGICAL arts
Eyelid and Facial Plastic Surgery

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AOsurgicalarts.com

PERSONAL INFORMATION (Please print and complete entire form)

Name Date

Date of Birth Social Security Number M / F

Address

City State Zip

Cell Phone Home Phone

Email Address

Occupation Employer

Single____ Married____ Domestic Partnership_____ Widowed_____ Divorced_____

Spouse/Emergency Contact Relationship

Address Phone

Complete if Patient is under 18 years of age

Name of Guardian Date of Birth

Employer Phone Number

Insurance Information

Are you responsible for the payment of your fees? Yes_____No_____If not, who is?

Name Relationship DOB

Primary Medical Insurance

ID # Group #

Secondary Medical Insurance

ID # Group #

Workers Compensation (job injury).

Case#

Signature **DATE**

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W: AOsurgicalarts.com E: info@aosurgicalarts.com

PATIENT NAME: **DATE OF BIRTH:**

REASON FOR CONSULTATION:

LIST ALL TREATING PHYSICIANS (PLEASE INCLUDE ADDRESS AND PHONE NUMBERS)

Referring Physician	
Cardiologist	
Ophthalmologist	
Optometrist	
Dermatologist	
Primary Care Physician	

LIST ALLERGIES TO MEDICATIONS AND REACTIONS

	MEDICATION NAME	REACTION
1		
2		

REVIEW OF SYSTEMS:

Do you currently have any problems in the following areas?

		Yes	No
Allergic/Immunologic			
	Hay fever symptoms		
	Head allergy symptoms		
	Seasonal allergies		
Cardiovascular (Heart/Blood Vessels)			
	High blood pressure		
	Pace Maker		
	Other		
Constitutional Symptoms			
	Fever		
	Muscle Pain		
	Weight Loss		
Eyes			
	Blurred Vision		
	Burning		
	Chronic infection of eye or lid		
	Distorted vision (halos)		
	Double vision		
	Dryness		
	Excess tearing/watering		
	Occasional tearing		
	Eye pain or soreness		
	Flashing lights		
	Fluctuating visual acuity		
	Glare/Light sensitivity		
	Loss of side vision		
	Loss of vision		
	Mucous discharge		
	Redness		
	Tired eyes		
	Cataracts		
	Prominent eyes		
	Drooping eyelids		
	Lazy eye		
	Crossed eye		
	Glaucoma		
	Macular degeneration		
	Keratoconus		
	Floaters		
	Foreign body sensation		
	Itching		
	Sties/Chalazion		

	Yes	No
Ears, Nose, Mouth, Throat		
Chronic cough		
Dry throat/mouth		
Pain with chewing		
Post-nasal drip		
Runny nose		
Sinus congestion		
Endocrine		
Diabetes		
Thyroid disorders		
Other		
Gastrointestinal (Stomach/Intestines)		
Genitourinary		
Genitals/kidney/bladder		
Hematologic/lymphatic		
Blood		
Lymph nodes		
Swelling		
Integumentary (Skin or Breast)		
Neurological		
Psychiatric		
Depression		
Other		
Respiratory		
Asthma (childhood/adult)		
Chronic Bronchitis		
Skeletal		
Back Pain		
Joint Pain		
Muscle Pain		

PAST HISTORY

List all medications and vitamins you currently take

Medication Name	Dose	Frequency

List all eye medications and/or ointments you currently take or use

Medication Name	Dose	Frequency

List all illnesses (list specific disease)

List any surgeries you have had including cosmetic and eye procedures

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FAMILY HISTORY includes Mother, Father, Sister, Brother, Grandparents, Aunt, Uncle						
		Yes	No	Relationship to patient	Maternal	Paternal
	DISEASE					
	Allergies					
	Asthma					
	Blindness					
	Cataract					
	Eczema					
	Glaucoma					
	Macular Degeneration					
	Retinal Detachment					
	Retinoblastoma					
	Arthritis					
	Cancer					
	Diabetes					
	Heart Attacks					
	High blood pressure					
	Keratoconus					
	Kidney Disease					
	Lupus					
	Sjogren's Syndrome					
	Stroke					
	Thyroid Disease					
	Tuberculosis					
	Other					
SOCIAL HISTORY						
	Current Occupation					

		Yes	No	Comments
	Do you drink alcohol?			
	If YES, how many glasses per day?			
	Do you smoke?			
	If YES, how many packs per day?			
	Transmissible blood bourne diseases (HIV, Hepatitis, Herpes)?			

I have completed the medical questionnaire and to the best of my knowledge confirm the accuracy of the answers.

Patient Signature:	Date:
Guardian of Patient:	Date:
Physician Signature:	Date:

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PAYMENT AND BILLING POLICY
We are committed to providing you with the best service possible. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to do this, we need your assistance and your understanding of our payment policy.

Payment for medical care is due at the time the services are rendered unless payment arrangements have been approved in advance by our staff.

INSURANCE BILLING
Co-payments are due at the time of the office visit.

We will be happy to submit claims to your insurance if you have provided us with the necessary insurance information. We require a copy of your insurance card that lists the name of the insurance company, address, telephone number, and policy/group numbers. It is your responsibility to bring a current referral from your primary care physician or a completed claim form for each visit if this is required by your insurance.

While the filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility. Regardless of what your insurance pays, your account is due in full within 90 days. Balances over 60 days are subject to a 1 ½ % per month finance charge.

MEDICAID INSURANCE
It is important that you bring your current Medicaid card to every office visit. It is also your responsibility to bring your current referral form from your primary care physician if required.

NON-INSURED OR SELF-PAY
Payment is due in full at the time of the office visit.

Non-emergency procedures require a 60% down payment prior to surgery.

Cosmetic surgeries are required to be paid in full prior to surgery. A $50 cosmetic consultation fee is due at the time of the initial office visit and will be applied to future cosmetic surgery if performed within 1 year.

If you do not have insurance or if your insurance does not cover the proposed surgery, our billing manager will meet with you to set up a payment plan that works for you. You will need to sign a payment agreement before any surgery can be scheduled.

We realize that temporary financial problems may affect timely payment on your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

Signature **DATE**

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

In accordance with the Federal Truth-in-Lending Act which requires all doctors to give their patients complete information in connection with extensions of credit, please be advised of the following credit policies which apply in this office. You may have the option either to:

1. Have an open 30 day account in which statements will be sent out monthly and payment in full will be due within 25 days and prior to the succeeding monthly statement. (Not applicable to cosmetic surgeries—payment required to be paid in full prior to surgery.)

2. Discharge the account in a period of 90 days by paying ¼ down and ¼ per statement over a period of 3 months. No interest charges will be made unless the account is not discharged as per agreement; in which case a monthly charge of 1 ½ % per month (annual percentage rate of 18%) may be made on the unpaid balance with a minimum charge of 50 cents per month. (Not applicable to cosmetic surgeries—payment required to be paid in full prior to surgery.)

I/we acknowledge receipt of a copy of this agreement and agree to pay costs and/or a reasonable attorney's fee if any delinquent balance is placed with an agency for collection or suit.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize my physicians to release any information related to the course of my examination of treatment to my medical insurance carrier for preauthorization requirements and payment of claims.

AUTHORIZATION TO PAY BENEFITS: I hereby authorize payment directly to the supplier of medical service.

Signature **DATE**

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HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to you past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment
We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment
Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations
We may use for disclose, as needed, you protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients in our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of an appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroner, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights to your protected health information.

You have the right to inspect and copy your protected health information.
Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information.
This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

You physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another healthcare professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any such changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

The signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Signature	**DATE**

PATIENT PHOTOGRAPHIC/VIDEO AUTHORIZATION AND RELEASE

I consent to the filming and taking of photographs by AO Surgical Arts of me or parts of my face and body in connection with the cosmetic ore reconstructive procedure(s) to be performed by Dr. Richard L. Anderson and/or one of his associates.

I understand that such photographs and/or video may be utilized or shown in any print, visual or electronic media, for the purpose of informing the medical profession about plastic surgery methods.

Neither I, nor any member of my family, will be identified by name in any publication. I understand that in some circumstances the photographs may portray features which could make my identity recognizable.

I understand that I have the right to revoke this authorization in writing at any time, but if I do so it won't have any effect on any actions taken prior to my revocation. If I do not revoke this authorization, it will expire ten years from the date written below. I understand that I may refuse to sign this authorization and such refusal will have no effect on the medical treatment I receive from Dr. Richard L. Anderson and/or one of his associates.

I understand that the information disclosed, or some portion thereof, may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

I release and discharge the treating physician, and all parties from all rights that I may have in the photographs and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of the photographs.

I GRANT THIS REQUEST AS A VOLUNTARY CONTRIBUTION IN THE INTEREST OF PUBLIC EDUCATION AND CERTIFY THAT I HAVE READ THE ABOVE AUTHORIZATION AND RELEASE AND FULLY UNDERSTAND ITS TERMS.

Signature **DATE**

OR

I DO NOT WISH TO HAVE MY PHOTOS USED FOR RESEARCH OR PUBLIC EDUCATION PURPOSES.

Signature **DATE**

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