AUSTIN OCULOFACIAL PLASTICS
COSMETIC AND RECONSTRUCTIVE SURGERY

Today's Date:	Reason for Today's visit:

COSMETIC PATIENT REGISTRATION FORM

Patient's last name: First:	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:

Email Address:	Home phone no.:	Cell phone no.:

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

How did you hear about us?: ____

MEDICAL HISTORY

ALLERGIES/SENSITIVITES: ____ Latex Allergy (circle one): YES / NO

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

1.________________ 2.________________ 3.________________ 4.________________ 5.________________

MEDICAL HISTORY ☐ None

- ☐ Arthritis
- ☐ Asthma
- ☐ Lung Disease
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Kidney Disease
- ☐ HIV
- ☐ Cancer- Type:________________
  Treatment/chemo/radiation/surgery
- ☐ Liver disease (hepatitis)- Type:
  ____
- ☐ High Blood Pressure (hypertension)
- ☐ Irregular Heart Rhythm (atrial fib / heart block)
- ☐ Gastroesophageal Reflux Disease (GERD)
  Heart Failure (Congestive Heart Failure)

Other________________

SURGICAL HISTORY ☐ None

- ☐ Arthritis
- ☐ Asthma
- ☐ Lung Disease
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Kidney Disease
- ☐ HIV
- ☐ Cancer- Type: ________________
  Treatment/chemo/radiation/surgery
- ☐ Liver disease (hepatitis)- Type:
  ____
- ☐ High Blood Pressure (hypertension)
- ☐ Irregular Heart Rhythm (atrial fib / heart block)
- ☐ Gastroesophageal Reflux Disease (GERD)
  Heart Failure (Congestive Heart Failure)

Other________________

REFER A FRIEND

If you refer a friend and they book with us, you will get 10% off your next treatment with Dr. Paul at Austin Oculofacial Plastics!

Name: Email: Phone:

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I authorize a **$50.00 consultation fee/charge** which will go toward my visit and service.
I understand that I am financially responsible for any balance and authorize Austin Oculofacial Plastics to release any information required to process my claims.

Patient/Guardian signature ____________________ Date ____________

AUSTIN OCULOFACIAL PLASTICS
COSMETIC AND RECONSTRUCTIVE SURGERY

FREQUENTLY ASKED QUESTIONS REGARDING HIPPA

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 (HIPPA) of 1996 for your review. **AUSTIN OCULOFACIAL PLASTICS** is complying with HIPPA 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 HIPPA 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

AUSTIN OCULOFACIAL PLASTICS
COSMETIC AND RECONSTRUCTIVE SURGERY

GENERAL OFFICE AND FINANCIAL POLICIES

Name (*please print*):____Date__________________________

Please initial the lines below AFTER reading the following carefully:

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

We are pleased that you have chosen our office for your cosmetic and/or healthcare needs. We would like to familiarize you with how our services are billed, when we request payment from you and our credit policies. Please take the time to read this policy and if you have any questions please speak to the practice administrator or billing specialist.

Due to federal law, a **VALID IDENTIFICATION** (driver's license, ID card, passport, military ID) must be presented at **EVERY OFFICE VISIT**.

BILLING AND COLLECTION POLICY
Payment is due at the time services are rendered. We do not offer in-house payment plans for treatments, other than the use of CareCredit. All payments must be paid in full at the time of service. We accept cash, check, Visa, MasterCard, Discover and American Express. There is a $35 fee for any returned check.

Initial here:______________

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 will be applied accordingly ($50 for new patients and $25 for return/follow-up patients). Please note that there will be a $100 fee if you are scheduled for any procedure and you fail to provide at least 48-hour notice of cancellation of your appointment.

Initial here:______________

I have read, understand and agree to cooperate with the policies listed above.

____ _________________________
Patient Signature / Date of Birth Date

AUSTIN OCULOFACIAL PLASTICS
COSMETIC AND RECONSTRUCTIVE SURGERY

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

If the patient is a minor or unable to sign, complete the following:

Father____

Mother____

Guardian or other person/relationship____________________________________