AUSTIN OCULOFACIAL PLASTICS
COSMETIC AND RECONSTRUCTIVE SURGERY

Today's Date:	Primary Care Physician:

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

Occupation:	Employer:	Employer phone no.:

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.:
Name of Tertiary Insurance: Subscriber's Name:	Birth Date: / /	ID Number:	Group No.:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	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 any 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._____

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: _____
- ☐ Other: _____

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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

Name_____ Address_____

Telephone_____ City/State_____

Primary Care Physician

Name_____ Address_____

Telephone_____ City/State_____

Cardiologist

Name_____ Address_____

Telephone_____ City/State_____

_____ _____

Patient Signature ***Date***

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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

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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 healthcare needs. We would like to familiarize you with how our services are billed, which insurance claims we file on your behalf, 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) and **CURRENT INSURANCE CARD** must be presented at **EVERY OFFICE VISIT**. If your name does not match your insurance card, we will be unable to file your insurance and you will be responsible for payment in full for services rendered. 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. You should understand that the primary-insured is financially responsible for any balance not covered by their insurance including deductible, co-insurance, co-payment and any services excluded by their policy.

If you have Medicare primary: You have a deductible to pay at the beginning of each year. Once that deductible is met, Medicare pays 80% of the allowed charges. There is a 20% co-insurance due, and if you do not have a secondary insurance or your secondary does not cover 20% in full, you will be responsible for that balance at the time services are rendered.

Please note that we collect money based on verbal, faxed or internet communication with your insurance; if there is a miscommunication by your insurance carrier and the correct amount is not collected, you will receive a bill for the balance. Overpayments will not be refunded until all outstanding claims have been processed by insurance and balances settled.

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.

Initial here:_____

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. An interest rate of 1.5% per month may apply to any invoice over 30 days old. 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 which include, but are not limited to, a 33% agency fee (an additional 33% of what you owe) along with any and all attorney and/or court 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.

Initial here:_____

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 and MasterCard. There is a $35 fee for any returned check.

Initial here:_____

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CANCELLATION / MISSED APPOINTMENTS POLICY

If you are unable to keep your scheduled appointment, please give our office a minimum of 48 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/testing and you fail to provide at least 48-hour notice of cancellation of your appointment.

Initial here:_____

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 clinic to another physician, we need a written request from you. We require appointment for completion of forms (FMLA, insurance screening, prior authorizations, etc). If forms are sent or dropped off at our office to be completed on your behalf, a fee of $35 will be due before the form can be processed. You should allow 7 days for completion of any forms.

Initial here:_____

PRESCRIPTION REFILLS AND PREAUTHORIZATIONS

Prescriptions are typically given at office visits with enough refills to last until your next follow-up visit. You should inform the medical assistant at the BEGINNING of your visit about refills you need. Please make sure that the pharmacy on file for you is correct. In the event that a refill is needed sooner, you should contact your pharmacy so the refill can be requested electronically. If your insurance company requires a preauthorization for your medication, you can discuss options for a different medication with your pharmacist or insurance and have them contact us to request a change. We do not have access to your insurance company formulary (list of approved medications). If there is paperwork to be filled out, you may be required to be seen at a regular office visit so the appropriate documentation can be sent to your insurance.

Initial here:_____

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.

The physicians at Austin Oculofacial Plastics ***do not prescribe benzodiazepines (anxiety meds) for long-term use***. If your condition warrants repeated use of such medications, you will be referred to a Psychiatrist.

Prescriptions for class-2 controlled substances (currently includes hydrocodone for pain and stimulant medications for attention-deficit) must be carried physically by the patient from the office to the pharmacy. Law prohibits these prescriptions from being sent electronically or by fax or mail. Refills for these controlled substances are subject to a $10 administrative fee if there is no office visit at the time the refill is being picked up. Patients prescribed controlled substances agree to urine drug screening on an annual basis; additional urine drug screens may be required at the prescribing physician's discretion.

Initial here:_____

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

_____ _____

Patient Signature / Date of Birth Date

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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_____

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AUTHORIZATION FOR RELEASE OF INFORMATION

Records requested:

_____Complete medical records
_____ Records of care from_____to_____only.
_____ Other (please specify)_____
_____ Confer with another person orally about information in my record. Specify person under "TO".

Reason for Release: (Article 4495b, Sec. 5.08(j) Texas Revised Civil Statutes require that an authorization for release of medical records include "the reason or purpose for the release.")

_____ Change of Physician or Patient Moving _____ Workers Compensation or Disability Claim
_____ Application for Insurance Coverage _____ Other:_____
_____ Consultation with another physician for (condition):_____

Records Requested FROM:

_____
Physician's Name

Address:

_____
Street

_____
City/State/Zip

_____
Fax #

Send Records TO:

Dr. Sean Paul, MD

Address:

4316 James Casey Street,
Austin, Texas 78730

Fax #: 512-642-8186

I understand that a reasonable amount of time (not to exceed 30 days) may be required to move my records. If possible, please send by:_____

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. This authorization expires in one year.

Patient's Full Name (Please Print):_____

Date of Birth:_____ Social Security #:_____ Year Last Seen_____

Any other name(s) under which your records may be filed:_____

_____ _____
Patient's Signature Date

(Patient or person legally to consent on patient's behalf. State relationship to patient & reason patient is unable to sign)

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AUTHORIZATION FOR RELEASE OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION TO DESIGNATED PARTY

This Authorization grants permission to the Designated party(ies) named below to: make or confirm appointments; have access to x-ray, laboratory, or test findings; have access to telephone communication and answering machine messages as well as other common means of communication; **pick up sample medications**; be made aware of diagnosis, prognosis and treatment plans; have access to my financial health information and medical records.

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

Patient Name:_____ **Date of Birth**:_____

Designated Party:_____ **Relationship to Patient**:_____

Address:_____

Phone:_____

Designated Party:_____ **Relationship to Patient**_____

Address:_____

Phone:_____

The patient or patient's representative must read and initial the following statements:

1. I understand that this authorization will: (Must check one)
   ( ) expire 1 year from the date signed by the patient or patient's representative; or
   ( ) be effective for the lifetime of the patient unless revoked.

2. I understand that I may revoke this authorization at any time by notifying in writing; however, if I do revoke the authorization, it will not have any effect on any actions taken by ***Austin Oculofacial Plastics*** prior to their receipt of the revocation.

3. I understand that my treatment cannot be conditioned on whether I sign this authorization.

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

Signature of Patient or
Patient's Representative:_____ **Date**_____
(Form **MUST** be completed before signing or will not be valid)

Printed Name of Patient's Representative:_____**Date**_____