Ophthalmic *Plastic Surgery, Inc.*

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PATIENT INFORMATION

Thank you for the opportunity to participate in your medical care. We look forward to meeting you and appreciate the opportunity to be of assistance. We hope that this information will answer frequently asked questions regarding your upcoming visit to our office. Additional information is available on our website at www.opsindy.com. If after reading this you have further questions please do not hesitate to call the office. Anyone on our staff would be happy to assist you in any way that we can.

ABOUT OUR SPECIALTY

Our surgeons are among the few surgeons in Indiana who are members of the American Society of Ophthalmic Plastic and Reconstructive Surgery (ASOPRS). Membership in this specialized and exclusive organization is restricted to ophthalmologists who have been board certified by the American Board of Ophthalmology and who have received extensive training in the field of oculofacial plastic and reconstructive surgery.

Our specialty deals with all problems related to the eyelids, tear ducts, and orbit (area behind the eye). This includes aesthetic (cosmetic) surgery, incorporating procedures for the brows/forehead, and mid-face, and eyelids.

Common problems referred to our office include eyelid surgery, tear duct obstruction surgery, cosmetic surgery, reconstruction of the orbit and mid-face following injuries, tumors involving the eyelids or eye socket, care of artificial eye sockets and other problems related to the eye, tear duct, orbit and face.

FEES, BILLING AND INSURANCE

We participate in most health plans. Medicare, Aetna, Anthem, Cigna, Sagamore, United Healthcare are only a few of the many plans with which we participate. If you have any questions about your insurance or our billing policies please do not hesitate to contact us for further assistance.

APPOINTMENTS

Your first visit is for consultation only. Any surgeries will be scheduled for a later date.

Our office hours are Monday through Friday 8:00 AM to 5:00 PM (Eastern Standard Time). An after-hours answering service is available all other times. For your convenience, we may also be reached via email to the attention of our office manager at tammyr@midwesteye.com.

The following paperwork should be completed prior to your appointment and brought to the office with you along with a current government issued photo ID and any insurance cards.

PLEASE DO NOT MAIL

200 W 103rd Street, Suite 2020 • Indianapolis, IN 46290 • phone (317) 817.1976 (800) 237.6028 • fax (317) 817.1737

OPHTHALMIC PLASTIC SURGERY

Patient Registration Information

TODAY'S DATE _____

HOME INFORMATION

Last Name: _____ M.I. _____ First Name: _____

If patient is a minor, name of legal guardian/guarantor _____

Street Address: _____

City, State, Zip: _____

E-mail: _____ ☐ YES, PLEASE SEND ME SPECIAL INTERFACE E-MAIL OFFERS TO HELP ME LOOK MY BEST. I AM AWARE THAT I MAY UNSUBSCRIBE AT ANY TIME.

Home Phone: _____ Work Phone: _____ Cell Phone: _____

SSN: _____ Sex: M F Date of Birth: _____

Marital Status: Single Married Divorced Widowed Legally Separated

EMPLOYER/SCHOOL INFORMATION

Employment Status: Employed Retired Disabled Student Self-employed Unemployed

Employer Name: _____

Employer Address: _____

REFERRAL INFORMATION

Referring Physician: _____ Phone: _____

Primary Care Medical Doctor: _____ Phone: _____

INSURANCE INFORMATION

#1) Insurance Carrier _____ Group#: _____

ID#: _____ Relationship to Subscriber: Self Spouse Dependant Other

If subscriber is someone other than the patient, please complete the following:

SSN: _____ First Name: _____ M.I. _____ Last Name: _____

Sex: M F Date of Birth _____

#2) Insurance Carrier _____ Group#: _____

ID#: _____ Relationship to Subscriber: Self Spouse Dependant Other

If subscriber is someone other than the patient, please complete the following:

SSN: _____ First Name: _____ M.I. _____ Last Name: _____

Sex: M F Date of Birth _____

EMERGENCY CONTACT INFORMATION (other than home number)

Name: _____ Relationship to Patient: _____ Sex: M F

Phone: _____ Work Phone: _____ Cell Phone: _____

OPHTHALMIC PLASTIC SURGERY

PLEASE READ THIS ENTIRE AUTHORIZATION PRIOR TO SIGNING

FINANCIAL RESPONSIBILITY STATEMENT / RELEASE OF INFORMATION

I authorize the release of any medical information necessary to my insurance company and the payment of benefits to the physician for services received. I understand that this authorization remains valid unless / until I revoke it myself.

I acknowledge responsibility for payment of all medical fees regardless of insurance. The only exception will be charges for services covered under a contractual agreement that has been entered into between my physician and an Insurance company, HMO, or other managed care entity. If for any reason the account should become delinquent, I am liable to pay for all collection and legal fees.

☐ Yes, I authorize ☐ No, I do not authorize

PHOTOGRAPHY RELEASE

I consent that photographs may be taken in connection with the medical services I receive. I understood that such photographs shall be used in my medical record and may be shared with others, including but not limited to my Insurance carrier. I also give permission for these photographs and relevant information to be published for the purposes of medical research, education, or science. I specify that any such publication of these photographs will NOT include my name. I understand that this release remains valid until I revoke it myself.

☐ Yes, I authorize ☐ No, I do not authorize

CONSENT FOR BLOOD-BORNE INFECTIOUS DISEASE TESTING

I authorize my physician to test for blood-borne infectious diseases, including but not limited to hepatitis, Acquired Immune Deficiency Syndrome ("AIDS"), and Human Immunodeficiency Virus ("HIV"), as indicated medically or to protect the health of the care-givers of this office, as per protocol. The results of these tests will become part of my confidential medical record.

☐ Yes, I authorize this testing ☐ No, I do not authorize this testing

_____ _____

Signature of Patient or Patient's legal representative if Patient is unable to sign Date

_____

Printed name of patient or representative

Relationship to patient if patient is unable to sign _____

_____ _____

(Witness is required if someone other than the patient is signing on behalf of the patient) Date

OPHTHALMIC PLASTIC SURGERY

Patient History Form

TODAY'S DATE _____

Name: _____ Date of Birth: _____

Medication Allergies	Reactions:

History of Latex Allergy? _____Yes _____No Height: _____ Weight: _____
Do you or any of your family members have a reaction with anesthesia? _____Yes _____ No If yes, describe _____

Cardiologist: (if applicable) _____

REVIEW OF SYSTEMS – Do you have or are you being treated for any of the following problems?

System	Yes	No	Condition/Current Treatment/Surgery
Eye disease (eye injury, eye surgery)			
Constitutional (fever, weight loss, other)			
Ears (reduced hearing)			
Nose/Mouth/Throat (sinus problems, sore throat)			
Cardiovascular (heart, vascular, hypertension, heart attack)			
Pacemaker/Defibrillator, heart murmur, abnormal heart rhythm			
Respiratory (breathing problems, cough, asthma, sleep apnea, hay fever)			
Gastrointestinal (diarrhea, vomiting, acid reflux, ulcer, Crohn's disease, ulcerative colitis, hepatitis)			
Neurological (weakness, stroke or mini-stroke, headaches, paralysis, seizures, Parkinson's disease)			
Genitourinary (male/or female organ problems, urinary problems, kidney stones, dialysis)			
Females – Pregnant? / Nursing?			
Dermatologic (skin rashes, skin cancer)			
Musculoskeletal (arthritis, rheumatoid disease, gout, osteoporosis)			
Diabetes			
Thyroid			
Immunologic (lupus, Sjorgren's Syndrome, scleroderma, any immune deficiency)			
Psychiatric (depression, bipolar, schizophrenia)			
Hematologic (bleeding tendency, anemia, leukemia, lymphoma)			
Cancer (type)			

FAMILY HISTORY

YES	NO	Heart Disease
YES	NO	High blood pressure
YES	NO	Diabetes
YES	NO	Cancer
YES	NO	Known genetic diseases
YES	NO	Heart disease
YES	NO	Other problems_____

SOCIAL HISTORY

Marital Status Married Single Widowed

Currently Employed: Yes No

If yes, occupations: _____

Use of Tobacco/Alcohol/Illegal Drugs: Yes No

Comments: _____

Patient Name: _____ DATE _____

Current medications including vitamins, supplements, herbals, anti-inflammatories and aspirin. Attach list _____

Name of Medication	Taken for what condition	Dosage	Frequency

History of any surgeries, injuries or major illnesses:

Procedure	Reason	When

Please check Yes or No if you are experiencing any difficulty with the following:

Activity	Yes	No	Activity	Yes	No
Reading, watching TV, sewing			My droopy eyelids seem to be causing headaches in my forehead		
Difficulty driving			See better pulling my eyelids and eyebrows up with my forehead muscles or my fingers		
My eyelids push down on my eyelashes					
My droopy eyelids cause eye irritation			Other _____ _____		

Patient's Signature: _____ Date _____

Physician's Signature: _____ Date _____

Reviewed/Updated Date _____ Interval changes YES NO MD Signature _____

OPHTHALMIC PLASTIC SURGERY
INTERFACE AESTHETIC SURGERY
HIPAA PRIVACY COMPLIANCE

Notice of Privacy Practices

As our Patient, a copy of Ophthalmic Plastic Surgery and Interface Aesthetic Surgery's Notice of Privacy Practices is available to you for your information/reference. This is available on our website at www.opsindy.com, from our receiption desk, or directly from our practice office and can be shared with you at any time upon request.

COMPLAINTS/COMMENTS

If you have any complaints concerning our privacy practices you may also contact the Secretary of the Department of Health and Human Services at 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201 (e-mail: ocrmail@hhs.gov.

YOU WILL NOT BE RETALIATED AGAINST OR PENALIZED BY US FOR FILING A COMPLAINT.

To obtain more information concerning this notice you may contact our Privacy Officer:

Tamara J. Richardson, Office Manager
Ophthalmic Plastic Surgery/Interface Aesthetic Surgery
200 W 103rd Street, Suite 2020
Indianapolis, Indiana 46290

SIGNATURE REQUIRED

Your signature is required below indicating that the entirety of the Ophthalmic Plastic Surgery and Interface Aesthetic Surgery Privacy Practices policy has been made available to you. A copy of this signature page will be provided to you as well as maintained in your medical chart.

_____ _____
Patient Signature Date

_____
Patient Name [Printed]

AUTHORIZATION FOR RELEASE OR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ DOB_____

Name of Person(s) and/or Organization(s)
who are being authorized to receive information:

_____ _____
_____ _____
_____ _____

I hereby authorize the release or use and disclosure of my individually identifiable health information (a/k/a Protected Health Information or PHI) as described above, I understand that this authorization is voluntary. I also understand that if the person or organization authorized to receive the information is not a health plan, health care provider, or contracted business associate of this practice, the released information may no longer be protected by federal privacy regulations.
[NOTE: If a patient is unable to sign for themselves, is underage, or if there is Medical Power of Attorney in effect, a legal guardian or the POA must sign this release below as patient representative.]

_____ _____
Signature of patient, legal guardian or patient representative **Date**

Printed name of guardian or representative: _____

As appropriate, describe guardian's or representative's relationship to the patient:

Witness:_____ **Date:** _____
(Witness is required if someone other than the patient is signing on behalf of the patient.)