



Chart No. \_\_\_\_\_

# Oculofacial & Plastic Surgery

CONSULTANTS

## Patient Information

**\*All bolded materials must be completed by patient\***

**\*First Name:** \_\_\_\_\_ **MI:** \_\_\_\_\_ **\*Last Name:** \_\_\_\_\_

**\*Sex:** \_\_\_\_\_ **\*Date of Birth:** \_\_\_\_\_

**\*Address:** \_\_\_\_\_

**\*City:** \_\_\_\_\_ **\*State:** \_\_\_\_\_ **\*Zip:** \_\_\_\_\_

**\*Phone (Home):** \_\_\_\_\_ **\*Phone (Cell):** \_\_\_\_\_

**\*Contact Preference:** Home  Cell  Permission to call: Yes  No

Permission to text: Yes  No

**\*Email Address:** \_\_\_\_\_

I would like to receive emails about special offers: Yes  No

**\*Primary Insurance:** \_\_\_\_\_ **\*Secondary Insurance:** \_\_\_\_\_

### **\*Emergency Contact 1**

**\*Name:** \_\_\_\_\_ **\*Phone:** \_\_\_\_\_ (home/cell)

**\*Relation to Patient:** \_\_\_\_\_

### **Emergency Contact 2**

**Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ (home/cell)

**Relation to Patient:** \_\_\_\_\_

**OPSC may reach out to the Emergency Contact(s) listed above regarding**

**All Healthcare, Scheduling, and Payment Information**

**Only Scheduling and Payment Information**

**Only for purposes of contacting me, once all direct patient contact avenues have been exhausted**

For Medicare reporting purposes we ask that you fill out the demographic information below:

Patient's preferred language: \_\_\_\_\_

Patient's race: \_\_\_\_\_

Patient's ethnicity:  Hispanic or Latino  Not Hispanic or Latino

Patient's marital status:  Married  Single  Divorced  Separated  Widowed  Partner

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How did you learn about our services?

Doctor Referral

Name of Doctor: \_\_\_\_\_

Friend or Relative

Name of Friend/Relative: \_\_\_\_\_

Newspaper or Magazine

Name of Newspaper/Magazine: \_\_\_\_\_

Our Website

By signing this authorization below I acknowledge the following:

- The information I have provided above is correct and most current to the best of my knowledge
- That failure to notify Oculofacial & Plastic Surgery Consultants (OPSC) of any changes to my contact information and insurance(s) in a timely-manner may result in a delayment of treatment and/or additional out-of-pocket costs due to the time-sensitive manner of insurance authorizations for treatments and procedures.

\* \_\_\_\_\_

Patient Signature

\_\_\_\_\_

Date

\* \_\_\_\_\_

Witness Signature

\_\_\_\_\_

Date



# Oculofacial & Plastic Surgery

CONSULTANTS

## Notice of Privacy Practices

This Notice is Effective Immediately

Please review the following to learn how we use and disclose medical information about you and your rights concerning these uses and disclosures.

### **How We Use and Disclose Your Information**

We will obtain your written authorization for any uses and disclosures of Protected Health Information (PHI) not described in the Notice of Privacy Practices.

Treatment, Payment, and Health Care Operations. We may use your PHI in order to provide your medical care; to bill for our services and to collect payment from you or your insurance company; and for the general operation of our business.

Marketing, Fundraising, and Sale of PHI. We will obtain your prior written authorization before sending you certain marketing communications. We may use or disclose your demographic information in order to contact your health information without your prior written authorization.

We may use your PHI as otherwise authorized or required by law for such purposes as:

- Public health reporting and oversight activities
- Judicial, administrative, or law enforcement proceedings
- Complying with workers' compensation laws
- Communicating with your family or caregivers
- Sending appointment reminders

You Have the Right to:

- Request certain restrictions on our use and disclosure of your PHI
- Request communications from us by specific means or locations.
- Inspect and copy your medical record.
- Ask us to correct the information in your medical record.
- Receive an accounting of disclosures of your PHI by our practice.
- Be notified in the case of a breach of unsecured PHI.

Oculofacial & Plastic Surgery Consultants implements measures to ensure we are always HIPAA compliant. Please speak with our staff to obtain a copy of our full HIPAA policy.



# Oculofacial & Plastic Surgery

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## **ACKNOWLEDGMENT: RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I have received a copy of Oculofacial Plastic Surgery Consultants, PA (OPSC) Notice of Privacy Practices effective immediately.

\* \_\_\_\_\_  
Patient Name

\* \_\_\_\_\_  
Patient Signature Date

### **For the legal guardians of patients under the age of 18 years:**

I am a parent or legal guardian of \_\_\_\_\_ (patient name). I have received a copy of OPSC's Notice of Privacy Practices effective immediately.

Name of guardian (please print): \_\_\_\_\_

Relationship to Patient:  Parent  Legal Guardian

\_\_\_\_\_  
Signature Date

### **FOR CLINIC USE ONLY:**

If the individual or parent/legal guardian did not sign above, staff must document when and how the Notice was given to the individual, why the acknowledgment could not be obtained, and the efforts that were made to obtain it. Notice of Privacy Practices effective immediately, given to individual on \_\_\_\_\_ (date)

In Person  Mailing  Email  Other

Reason individual or parent/legal guardian did not sign this form:

Did not want to  Did not respond after more than one attempt  Other

The following good faith efforts were made to obtain the individual or parent/legal guardian's signature. Please document with dates, times, individuals spoken to, and outcome, as applicable, the efforts that were made to obtain the signature. More than one attempt must be made.

In person conversation  Telephone contact  Mailing  Email  Other

Staff Name (please print): \_\_\_\_\_ Title: \_\_\_\_\_ Staff

Signature: \_\_\_\_\_ Date: \_\_\_\_\_





# Oculofacial & Plastic Surgery

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## Patient Financial Policy

Oculofacial & Plastic Surgery Consultants (OPSC) consider it a privilege that you have chosen us for oculofacial plastic surgery care. OPSC provides both reconstructive and cosmetic/aesthetic plastic surgery treatments for the eyes. Our providers implement reconstructive plastic surgery approaches to improve body function due to birth defects, injury, disease, or aging. In addition, our providers also provide cosmetic and aesthetic services to partner with our patients to help them reach their aesthetic goals. We strive to inform you of all the medical aspects involved as well as our financial policy. Please read the following and sign prior to your procedure. We are happy to answer any questions that you may have.

### Insurance Related Consultations and Services:

- Your insurance card is required at the time of check-in.
- If we participate with your insurance applicable consultation fees will be billed to your insurance and you will only be expected to pay deductibles, co-insurances, copays and any non-covered services.
- You will be expected to pay any copays at the time of service.
- Your insurance may have separate copays for the consult visit itself and any other additional services that are provided at your consult visit, i.e. photos & photo interpretation, nasal endoscopy, probe and irrigation of the tear ducts. OPSC will always bill your insurance first and will notify you of any costs they deem is your responsibility.
- As a courtesy, we will file your claims for you with your primary and secondary insurance carriers. Ultimately, you accept responsibility for payment in full to Oculofacial & Plastic Surgery Consultants, not your insurance.
- You will be quoted and expected to pay any amounts your insurance will not pay one week prior to your procedure. This will include our best estimate of only the surgeon's fee. The facility and anesthesia fees will be billed to you separately. Please contact those providers directly with any questions about their fees.
- If your insurance requires a referral, please have your primary care physician fax it to our office prior to your appointment or you may be rescheduled.
- We gladly accept cash, check, Mastercard, Visa, American Express, Discover and Carecredit. All checks should be made out to Oculofacial & Plastic Surgery Consultants. If your check is returned, you will be charged a return check fee and your checks will no longer be accepted for future payments.
- **The patient has the responsibility to immediately notify OPSC of any insurance policy changes and failure to do so may result in the accrual of additional out-of-pocket costs.**
  - Inaccurate or untimely information given to the staff that results in denial or noncoverage by your insurance company results in the guarantor being responsible for payment.



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- **It is the patient's responsibility to understand their benefit plan. It is their responsibility to know if a written referral or authorization is required to see specialists, if preauthorization is required prior to a procedure, and what services are covered.**
- For reconstructive procedures: All surgeon fees provided by OPSC are our best estimates dependent upon the patient's insurance policy.
  - All out-of-pocket portions of surgeon fees will be adjusted after the insurance payment received post-surgery.
    - In the case that the out-of-pocket cost is lower than expected, the patient may choose to receive a refund payment or elect to use the balance as a credit towards future appointments/treatments.
    - In the case that the out-of-pocket cost is higher than expected, the patient will be held responsible for the remaining balance.

### Cosmetic/Aesthetic Consultations and Services:

- All Cosmetic Consultation fees are \$95.00. This fee will be credited towards your procedure.
- A \$300.00 deposit is required in order to secure a date for your surgery. This fee is non-refundable and will be credited towards your procedure.
- We understand that unforeseen events happen. Upon proper notice you may reschedule your surgery one time.
- Payment for the balance of your surgery is due one week prior to your surgery date. If payment is not received the surgery will be cancelled. We accept cash, check, Master Card, Visa, American Express, Discover, and Care Credit.
- If you pay by check you will be required to pay two weeks in advance. If the check is returned, you will be charged a return check fee and your checks will no longer be accepted for future payments.
- You may ask our office staff or visit our website to apply for Care Credit and Alphaeon Credit. Please ask us what Care Credit and Alphaeon Credit terms we offer.

### Self-Pay Consultations and Services:

- For self-pay patients, payment in full is expected at the time of the office visit and prior balances must be paid prior to the following visit with the exception of emergency visits.
  - All office visits are \$95.00 and any other procedures or services are at additional costs which will be discussed with you.
  - Payments can be found on the OPSC self-pay fee sheet.

### Payment Plans

- It is the patient's responsibility to make payment arrangements with the practice to ensure that the practice has the correct contact information including phone numbers, mailing addresses, and email addresses.

- If there is an outstanding patient balance, the practice will mail all statements and make attempts to contact the patient via phone and email.
- Bills unpaid for after three statements have been sent to the patient may be turned over to a collection agency after 90 days unless other arrangements have been made.
- Patients with outstanding balances and no payment arrangements will not be seen by the practice until payment arrangements are made with a down payment, unless the patient is experiencing an emergency that requires immediate attention.
- Our practice is glad to work with our patients to find a reasonable and appropriate payment plan.

**Forms, Medical Records and Fees**

- There may be a fee associated with the completion of documents including forms. All documents will be completed within 7 business days and sent out upon receipt of payment.
  - Family and Medical Leave Act (FMLA) forms and other medical forms have an associated fee of \$25.00 to cover health professional time for completion of the form.
  - Work and School release letters will be provided at no cost to the patient.
  - Patients with multiple medical forms/documents will be charged a discounted rate form the additional forms.
- Hard copies of patient requested medical records have an associated fee of \$15.00 to cover printing costs. This is applicable only to hard copies and digital copies will be shared to patients at no cost via e-mail or fax.
  - Patients should be aware that these records may be found in their Athena Patient Portal.

**Authorization:**

I have read and fully understand the financial policy set forth by Oculofacial & Plastic Surgery Consultants. I agree to be responsible for my medical expenses regardless of insurance coverage. I authorize my insurance company and any other party to make payments directly to Oculofacial & Plastic Surgery Consultants. I agree to pay any cost incurred if my account should become delinquent. I have read, understand and agree to this financial policy and I accept full responsibility for any balance due. I understand and agree that the terms of this financial policy may be amended by the practice at any time without prior notification to the patient.

\* \_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\* \_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date





# Oculofacial & Plastic Surgery

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## Patient Insurance Policies

Oculofacial & Plastic Surgery Consultants (OPSC) does their best to ensure that all patients' insurances are verified for eligibility, ie. to know whether our providers are in-network with the patient's policy. Due to the high number of policy plans and specifications, it is not possible for OPSC to know the intimate details of each patient's personal insurance policy.

By signing below I acknowledge that I understand the following:

- That the primary relationship for insurance coverage is between myself and my insurance provider. I have the ultimate responsibility to know which practices and providers are in-network with my specific insurance plan.
- OPSC cannot be held responsible for any policy restrictions or coverage that the insurance company determines.
- OPSC is unable to provide me with out-of-pocket costs outside of the estimates provided by my insurance company to OPSC and that the exact cost will only be made known to OPSC and therefore to the patient after the services are completed.
- That I must notify OPSC if my insurance policy or providers have changed and that any delay in doing so will result in delay of services and cancellation of appointments or procedures among other potential consequences.
- That whatever my insurance company does not cover is my responsibility to pay in full. I understand that I have the right to arrange a prepayment plan with OPSC based on the estimate provided by OPSC.

By signing below, I acknowledge that I have read and understand the above relationship between OPSC, my insurance provider, and myself.

\* \_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\* \_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date



# Oculofacial & Plastic Surgery

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## Informed Consent: COVID-19

The novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. While Oculofacial and Plastic Surgery Consultants complies with state health department and the Centers for Disease Control and Prevention (CDC) infection control guidelines to prevent the spread of the COVID-19 virus, we cannot make any guarantees. Our staff and your provider are symptom-free and to the best of their knowledge, have not been exposed to the virus.

Since this facility provides healthcare services, people (including other patients or staff) could be exposed or infected, with or without their knowledge. In order to reduce the risk of spreading COVID-19, we have employed reasonable precautions including daily screening of healthcare workers and more frequent disinfectant protocols.

By signing below you acknowledge that you understand the following:

- COVID-19 is extremely contagious and is believed to spread by person-to-person contact, and as a result, federal and state health agencies recommend social distancing.
- That my provider and medical practice listed above has put in place reasonable safety measures to help reduce the spread of COVID-19
- Even if you do not have any symptoms, you may have a COVID-19 infection, and that having an appointment/treatment/surgery can lead to a higher chance of complication and death
- Exposure to COVID-19 before, during, and after my appointment/treatment/surgery may result in the following: a positive COVID-19 diagnosis, extended isolation, additional tests, and hospitalization, up to and including: the need for treatment in intensive care (ICU), short-term or long-term intubation, other complications, and death.
- COVID-19 may cause additional risks, some of which may not be known at this time and that any procedure may put me at increased risk for becoming infected with COVID-19

By signing this consent form you acknowledge that you have read this consent form or that it has been read to you and accept the risk and give your permission to proceed with medical treatment provided by Oculofacial and Plastic Surgery Consultants. You have been given the choice to be treated at a later date and understand the potential risks of delaying medical treatment. You have answered all screening questions truthfully in regards to any potential exposure to COVID-19 (via travel, family, etc.) and any symptoms you currently exhibit.

\* \_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\* \_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date