OPSGA

ERIC BAYLIN MD JAVIER SERVAT MD

OCULOFACIAL PLASTIC SURGEONS OF GA

Phone: 770-604-4141 Fax: 770-604-4140

Please complete this form and provide a picture ID and insurance card(s) to the front desk

Name: _____

LAST FIRST MIDDLE INITIAL

Mailing Address: _____

STREET CITY, STATE ZIP CODE

Phone # Home: _____**Cell**:_____ **Sex**: M_____ F_____

SSN:_____ **Birthdate**:_____ **Email:**_____

Age: ____ Marital Status: (Please Circle): Married Divorced Single Widow(er) Partnered

Emergency Contact Name:_____ **Phone**:_____

Emergency Contact Relationship: _____

Employed (Please Circle): Yes No Retired Occupation_____

May we call you at work: Yes No Work Phone:_____Employer:_____

<u>If you would like your insurance billed for this visit you **MUST** complete the health insurance information below:</u>

Primary Health Insurance Company:_____**Insured ID #**_____

Policyholder's Name:_____**Group ID#**:_____

Policyholder's DOB:_____SSN#:_____Relationship:_____

Secondary Health Insurance Company: _____**Insured ID #**:_____

Policyholder Name:_____**Group ID #**:_____

Policyholder's DOB:_____SSN#:_____Relationship:_____

The American Recovery & Reinvestment Act of 2009 requires we gather additional information from you about your background. Thank you for answering the following three questions. Please circle the correct answer:

1. **Race:** Asian Black, African American American Indian/Alaska Native
   White Hispanic/Latino Native Hawaiian/Pacific Islander Declined
2. **Primary Language:** English Spanish Other_____
3. **Ethnicity:** Hispanic/Latino Non-Hispanic/Latino Declined

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Referring Physician Name_____Speciality_____

Address_____

Phone # ( )_____ Fax # ( )_____

Primary Physician Name_____Speciality_____

Address_____

Phone # ( )_____ Fax # ( )_____

Other Physician (Regularly seen for continual care)

Physician Name_____Speciality_____

Address_____

Phone # ( )_____Fax # ( )_____

Best way to reach you with test results: ☐ **Home Phone** ☐ **Cell Phone** ☐ **Email (fill in space on page 1)**

In the case of <u>favorable</u> test results, may we leave a message on your answering machine? ☐ **Yes** ☐ **No**

I give permission for OPSGA, LLC. and office staff to discuss my health status with the following people:

Name:_____Phone :_____Relationship:_____

Name:_____Phone:_____Relationship:_____

Patient's Signature:_____ **Date**:_____

<u>If the patient is a minor, please complete:</u>

Mother's Name_____ DOB:_____ Phone:_____

Father'sName_____DOB:_____Phone:_____

The child lives with (Please circle): Mother Father Both Parents Other:_____

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Heath Information as of (today's date):_____

Confidential Record: Information contained here will not be released unless you have authorized us to do so.

Name: _____**Age:**_____**Height**:_____**Weight**:_____

Reason for today's visit:_____

List previous surgeries including the procedure, date and surgeon:

List any serious illness or accidents:

_____

Smoking Status (Please Circle):

Current Every Day Smoker Current Some Day Smoker Former Smoker Never Smoker Unknown

Medical History: *Please check below if you have, or have had any of these medical conditions:*

- ☐ Alzheimer's/significant memory loss
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer Type:_____
- ☐ Congestive Heart Failure
- ☐ Depression
- ☐ Diabetes
- ☐ Epilepsy/Seizures
- ☐ Fibromyalgia
- ☐ Glaucoma
- ☐ Hemophilia/ Excessive Bleeding
- ☐ Hepatitis
- ☐ Herpes Simplex/Fever Blisters
- ☐ High Blood Pressure/Hypertension
- ☐ HIV or AIDS
- ☐ Hay Fever/Allergies
- ☐ Infections:_____
  - MRSA? ☐ Yes ☐ No
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Sinus Infections/Problems
- ☐ Sleep Apnea
  - ☐ CPAP Machine
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Other:_____

Do you have bleeding/bruising problems?	☐ No	☐ Yes	If yes, describe:_____
Do you have problems with scarring?	☐ No	☐ Yes	If yes, describe:_____
Do you have a history of problems w/ anesthesia?	☐ No	☐ Yes	If yes, describe:_____
Do you use recreational drugs?	☐ No	☐ Yes	If yes, describe:_____
Do you dip or chew tobacco?	☐ No	☐ Yes	If yes, how much per day:_____
Do you drink alcohol?	☐ No	☐ Yes	If yes, how much?_____
			If yes, how often?_____

The above information is accurate and complete to the best of my knowledge.

Patient's Signature: _____ **Date**: _____

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Patient's Name:_____

Name of Pharmacy:_____

Address _____**Phone:**_____

Please list street name and city of pharmacy.

Do you have any known drug allergies? ☐ **NO** ☐ **YES, please complete information below**

	Allergies: Drugs / OTC Medicine, etc.	Side Effect
1.		
2.		
3.		
4.		

List the name of all medications, vitamins and supplements you are presently taking or have taken within the last month. Please include the name of the drug, dosage and frequency.

	Medications/Supplements	Strength	Frequency of Use
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			

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Financial Policy & Insurance Agreement

1. Your insurance policy is a contract between you, your employer (if applicable), and the insurance company. We are not a party to that contract. Our relationship is with you, not your insurance company. We will not become involved in disputes between you and your insurer regarding deductibles, co-payment, covered charges, secondary insurance and "usual and customary" charges. As your medical provider, we will only supply information to facilitate claim processing.
2. Your co-pay amount (for a medical specialist) set by your insurance company is due at the time of service. You are ultimately responsible for payment of all charges received in our office, including but not limited to insurance deductibles, lab fees, out-of-pocket expenses, co-insurance amounts or any outstanding balances not covered by health insurance.
3. After your insurance company has processed and or paid your claim, all outstanding balances are due within 30 days or after you have received your first statement. If your balance has not been paid on or before the 90th day, it will automatically be turned over to a collection agency and it will have a negative affect on your credit report. You will also assess a $25 fee and be responsible for all legal fees. Please be sure to make all payments in a timely manner to avoid this action.
4. A fee of $25 fee will be added to your account for any check dishonored by your bank.
5. Returned checks of $500 or more will be assessed a fee equal to 5% of the amount of the check.

PATIENT RESPONSIBILITY

- It is your responsibility to provide us with your current health insurance information, as well as your correct address and telephone number at each visit.
- It is your responsibility to confirm with your insurance carrier that Dr. Baylin / Dr. Servat are in your network prior to your appointment. If you choose to see our doctor out-of-network, you will be responsible for payment in full.

SCHEDULING SURGERY

Please carefully consider your surgical date before scheduling. Your surgery requires the coordination of insurance authorizations, the surgeon, anesthesiologist, facility, and any special supplies. Rescheduling procedures requires significant time and expense, particularly if the operating room goes unused because of a late cancellation. Therefore, we respectfully request your cooperation and understanding of the surgery scheduling process and our cancellation policy. You will never be penalized for canceling a surgery due to failed insurance coverage, or if your primary care physician will not grant you surgical clearance.

- *Within 30 days of your surgery,* if you **cancel or reschedule** your surgery date, you will be charged a $500 fee. This fee must be paid before a new date will be scheduled.
- The rescheduling and cancellation fees are not covered by your insurance.

I have read, understand, and agree to the insurance and financial policies stated above. I agree that I have had the opportunity to discuss any questions or concerns regarding the above with one of the Insurance Specialists for the practice.

Signature of Patient or Legal Guardian:_____Date:_____

Print Name of Signer:_____

Patient Name (if not the Signer):_____ _____DOB:_____

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Your Prescriptions and Your Privacy

A new version of technical standard that is recommended by the federal regulators encourages greater use of electronic health records. These standards allow physicians using electronic health record software to electronically access prescription information from pharmacies and health plans while also making use of electronic prescriptions.

I hereby allow disclosure of my pharmacy as well as prescriptions and over the counter medications.

Signature of Patient or (Legal Guardian):_____Date:_____

Print Name of Signer:_____

Patient Consent for Use/Disclosure of Health Care Information

With my consent, **Oculofacial Plastic Surgeons of Georgia, LLC**, (**OPSGA**) may use and disclose my protected healthcare information to carry out treatment, payment, and healthcare operations. I further understand OPSGA may need to disclose protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax or email. I understand OPSGA originates and maintains paper and electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

For a more complete description of such uses and disclosures, I will refer to OPSGA's *Notice of Privacy Practices.* This document is available for review in the office, on our website (www.opsga.com) or may be obtained by written request to OPSGA's Atlanta office. OPSGA reserves the right to revise its *Notice of Privacy Practices* at any time.

I have the right to request that OPSGA restrict its use or disclosure of my protected health information. While OPSGA is not required to agree to my requested restrictions, if it does, it is bound by this agreement.

I may revoke my consent in writing, except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, due to the restrictions on disclosure of healthcare information and its effect on the ability to perform diagnosis and treatment, OPSGA may decline to provide treatment to me.

My signature below indicates I have been given the opportunity to review OPSGA's *Notice of Privacy Practices* and I am consenting to OPSGA's use and disclosure of my protected healthcare information.

Signature of Patient or (Legal Guardian):_____Date:_____

Print Name of Signer:_____

Patient Name (if not the Signer):_____ DOB:_____

Optional Photo release:

I, _____, hereby authorize the release of my photographs to Oculofacial Plastic Surgeons Of GA LLC, (a.k.a. OPSGA) for educational use in any and all of its printed and digital publications. I waive the right to inspect or approve the finished product, wherein my photo appears in print or digital format. I acknowledge this permission is voluntary; I will receive no financial compensation. This permission is effective indefinitely, or until I give written notice breaking this agreement.

Patient Signature: _____Date: _____