

OPSGA



ERIC BAYLIN MD JAVIER SERVAT MD JENNA KIM MD
OCULOFACIAL PLASTIC SURGEONS OF GA

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: _____

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: _____

Race: Asian Black, African American American Indian/Alaska Native White Hispanic/Latino
Native Hawaiian/Pacific Islander Declined

Primary Language: English Spanish Other _____

Ethnicity: Hispanic/Latino Non-Hispanic/Latino Declined

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 favorable 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:** _____

If the patient is a minor, please complete:

Mother's Name _____ DOB: _____ Phone: _____

Father's Name _____ DOB: _____ Phone: _____

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

Health 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:

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

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.			

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 effect 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 / Dr. Kim 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 require 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 is 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: _____

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: _____