OPHTHALMIC PLASTIC SURGEONS OF TEXAS, P.A.
OPST – THE SURGERY CENTER, LLC
Marc N. Longo, M.D. Audrey E. Ahuero, M.D.

Patient Name: _____
Address: _____
City: _____ **State:** _____ **Zip Code:** _____
Best Phone#: _____ **Type: ❑ Home ❑ Cell Ok to leave a message? ❑ Yes ❑ No**
To confirm appointments, do you prefer we: ❑ Leave Voicemail or ❑ Send Text Message
Other Phone#: _____ **Type: ❑ Home ❑ Cell Ok to leave a message? ❑ Yes ❑ No**
Date of Birth: _____
Sex: ❑ Male ❑ Female
Marital Status:
❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed
Social Security Number: _____
Employer Name: _____
Work Phone: _____ **Ok to call & leave message? ❑ Yes ❑ No**
Emergency Contact: _____
Phone Number: _____ Relationship: _____

Primary Care Doctor: _____
Address: _____ City: _____
State: _____ Zip Code: _____ Phone #: _____
Referring Doctor/Clinic: _____
Address: _____ City: _____
State: _____ Zip Code: _____ Phone #: _____

Patient's Personal Email Address: _____
Patient's Pharmacy Name: _____
Address: _____
Phone Number: _____

Race and Ethnicity Identification
Are you of Hispanic or Latino descent? Persons of Cuban, Mexican, Puerto Rican, South American, or Spanish
- ❑ YES
- ❑ NO

You must select at least one race, regardless of ethnicity designation. More than one response can be selected.
- ❑ **American Indian or Alaska Native**: A person having origins in any of the original peoples of North and
- ❑ **Asian**: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian
- ❑ **Black or African American**: A person having origins in any of the black racial groups of Africa.
- ❑ **Hispanic or Latino:** A person of Cuban, Mexican, Puerto Rican, South American, or Spanish culture or origin.
- ❑ **Native Hawaiian or Other Pacific Islander**: A person having origins in any of the original peoples of
- ❑ **White**: A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

Preferred Language: _____

_____ _____
Signature of Patient or Legal Representative **Date**

Financial Information

Patient's Payment Details – Guarantor (Person responsible for paying the bill)

Guarantor Name: _____

SSN: _____DOB:_____

Relation to Patient: _____

Primary Insurance Company - Subscriber and Insurance Company Details

Insurance Company: _____

Primary Subscriber Name: _____

Date of Birth: _____

MemberID#: _____

Secondary Insurance Company – Subscriber and Insurance Company Details

Insurance Company: _____

Subscriber Name: _____

Date of Birth: _____

MemberID#: _____

Privacy Contact Form

Persons who are involved in your care (family, friends, other doctors, etc.) may inquire about your treatment, lab results, prescriptions, appointment dates and times, etc. Please let us know with whom we may share information and their relationship with you. (Please note: in emergency situations or other situations outlined in our Notice of Privacy Practices we may share information with others who are not specifically listed on this form.)

Please list persons with whom we may share your information and their relationship to you:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Photographic Disclaimer and Consent

Dr. Longo and Dr. Ahuero both have teaching appointments and are clinical professors at MD Anderson Cancer Center and/or University of Texas medical school. By signing below, I hereby authorize the use of my still photographic image for educational or informative lecture purposes by OPST, Dr. Longo, and/or Dr. Ahuero. Patient names will not be published, and photos are generally cropped to the treated areas. I am aware that my still photographic image may also be used for marketing purposes such as the company website by OPST, Dr. Longo and/or Dr. Ahuero.

I hereby give my permission for such use without receipt of any financial consideration or compensation, and I waive any right I may have to inspect or approve the finished product that may be used in connection therewith.

I hereby release, discharge and hold harmless OPST, Dr. Longo, and/or Dr. Ahuero from any liability for the use, publishing or reproduction of my photographic likeness.

_____ _____

Signature of Patient or Legal Representative **Date**

OPHTHALMIC PLASTIC SURGEONS OF TEXAS, P.A.
AND OPST – THE SURGERY CENTER, LLC
PAYMENT, FINANCIAL RESPONSIBILITY, DISCLAIMER AND CONSENT

Payment Policy: Payment is due at the time professional services are rendered. For your convenience all major credit cards, personal checks, and cash are accepted.

Insurance Claim Filing: We accept MEDICARE, selected PPO, POS, and COMMERCIAL insurance plans. **PLEASE BE ADVISED THERE ARE SOME CLINICAL AND SURGICAL PROCEDURES THAT YOUR INSURANCE WILL NOT COVER OR MAY PROCESS AS OUT OF NETWORK; THEREFORE, BY SIGNING THIS DOCUMENT, YOU AGREE TO BE HELD FINANCIALLY RESPONSIBLE FOR SERVICES RENDERED ON OR BEFORE THE TIME OF SURGICAL OR CLINICAL SERVICE.** The filing of your insurance claim is a courtesy to you and does not guarantee payment. The medical claim payment process can take up to forty-five days to complete, we ask for your patience while this process is taking place.

Surgical Predetermination Process: Predetermination takes place prior to surgery and requires that a letter of medical necessity, any photographs and/or testing be sent to your insurance company for review and possible approval. This process can take four to six weeks, and if surgery is approved, there is no guarantee of payment. **Should you wish to proceed with an unapproved surgical procedure, you will be asked to sign the waiver in lieu of insurance claim filing, and we will ask for payment in full. Ophthalmic Plastic Surgeons of Texas, P.A. and OPST – The Surgery Center, LLC will not refund any private pay monies collected on an unapproved surgery. You may wish to file the claim on your own and agree to accept what your insurance company PAYS YOU after the surgery has taken place.**

I understand that the doctors, billing department, and staff will make all reasonable efforts to collect payments due from any third party payors/insurance companies for approved services. In the event that the insurance company/third party payor refuses to pay for whatever reasons, I agree to be financially responsible for the remaining balance on my account.

Surgery Centers: Dr. Longo and Dr. Ahuero perform surgeries in several facilities, including our own surgery center. Please be advised that your surgery may be performed at a facility in which the doctors have a financial interest or part-ownership.

Medical/Surgical Assignment of Benefits and Release of Medical Information Agreement: I request payment of my authorized insurance benefits be made payable to Ophthalmic Plastic Surgeons of Texas, P.A. and OPST – The Surgery Center, LLC on my behalf for unpaid medical and/or surgical procedures present or future charges. I also authorize OPST, Dr. Longo, and Dr. Ahuero to release medical information and photographs to my insurance companies or agent, present or in the future, for claim purposes only.

I understand Dr. Longo/Dr. Ahuero/OPST will make all necessary attempts to protect my privacy under HIPPA law. I may also ask for a copy of the privacy policy of Dr. Longo/Dr. Ahuero/OPST.

Signature of Patient or Legal Representative **Date**

Ophthalmic Plastic Surgeons of Texas
OPST - The Surgery Center
7500 San Felipe, Suite 200
Houston, TX 77063

Notice of Privacy Practices and Patient Consent For Use and Disclosure of Protected Health Information

PATIENT NAME _____ **DATE** _____

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

I understand that Ophthalmic Plastic Surgeons of Texas and OPST - The Surgery Center may use or disclose my protected health information for treatment, payment or health care operations—which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Ophthalmic Plastic Surgeons of Texas and OPST - The Surgery Center has a detailed document called the *'**Notice of Privacy Practices**'*. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the *'Notice'* before signing this agreement. If I ask, Ophthalmic Plastic Surgeons of Texas and OPST - The Surgery Center will provide me with the most current *Notice of Privacy Practices*.

My signature below indicates that I have been given the chance to review such copy of the *Notice of Privacy Practices*. My signature means that I agree to allow Ophthalmic Plastic Surgeons of Texas and OPST - The Surgery Center to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Ophthalmic Plastic Surgeons of Texas and OPST - The Surgery Center has taken action relying on this consent.

SIGNATURE (Patient or Legal Custodian/Authorized Representative) _____ **DATE** _____

Relationship to Patient if signed by another party _____ **DATE** _____

You may obtain a copy of our *Notice of Privacy Practices*, including any revisions of our *'Notice'* at any time by contacting: Ophthalmic Plastic Surgeons of Texas and OPST - The Surgery Center, 7500 San Felipe, Suite 200, Houston, TX 77063. Phone: 713-953-9932.

FORM Us

Patient Name: _____ **Date:** _____

Reason for your visit today? _____

Are you interested in any of our cosmetic services, such as Botulinum Toxin (Botox) and Facial Fillers (Juvederm, Restylane), or skin care products? If yes, please indicate what interests you.

❑ **Yes**_____ ❑ **Not Interested**

Please list your current height and weight:

Height: _____ Weight: _____

Women of childbearing age: Are you pregnant or breastfeeding? ❑ Yes ❑ No

Medical History and Current Medications

Please list all medical/health problems & medications **(*PLEASE PRINT LEGIBLY*):**

Medical Conditions Do you have any of the following medical conditions?	
High Blood Pressure ❑ Yes ❑ No	
Diabetes ❑ Yes ❑ No	
High Cholesterol ❑ Yes ❑ No	
Heart Disease ❑ Yes ❑ No	
Cancer ❑ Yes ❑ No	
Abnormal Thyroid ❑ Yes ❑ No	
Anxiety/Depression ❑ Yes ❑ No	
Sleep Apnea ❑ Yes ❑ No	
Reflux ❑ Yes ❑ No	
Pacemaker/Defibrillator ❑ Yes ❑ No	
Other:	

Current Medications List below your current medications, including dosage, frequency, and how long have you been taking each medication

Do you take blood thinners? ❑ Aspirin ❑ Plavix ❑ Coumadin ❑ Other_____ **❑ None**

Please list any other Medications/Vitamins/Supplements you are taking:

Please list any Medication and/or Latex <u>ALLERGIES</u> (with the type of reaction):

Have you had the following immunizations, and if so when and where:

Pneumonia Vaccine? ❑ Yes, date/by whom:_____ **❑ No**

Influenza Vaccine? ❑ Yes, date/by whom:_____ **❑ No**

Have you had any Falls in the past year? ❑ Yes ❑ No If yes, how many times did you fall: ____

Were you injured in any of the falls? ❑ Yes ❑ No

Ever had problems with anesthesia or been told you have a difficult airway? ❑ Yes ❑ No

<u>Past Surgical/Hospitalization History</u> (*PLEASE PRINT LEGIBLY*)

Month/Year	**Surgical Procedure and whether or not Hospitalization was required**

Family History: Please check if your family has a history of the following conditions	**Diabetes**	**High Blood Pressure**	**Heart Disease**	**Stroke**	**Cancer**	**Mental Illness**	**Other**
Father: ❑ Alive ❑ Deceased Birth Year: _____ Age: ____							
Mother: ❑ Alive ❑ Deceased Birth Year: _____ Age: ____							
Paternal Grandfather: ❑ Alive ❑ Deceased Birth Year: _____ Age: ____							
Paternal Grandmother: ❑ Alive ❑ Deceased Birth Year: _____ Age: ____							
Maternal Grandfather: ❑ Alive ❑ Deceased Birth Year: _____ Age: ____							
Maternal Grandmother: ❑ Alive ❑ Deceased Birth Year: _____ Age: ____							

Social History Please check yes or no and *SPECIFY* answer:

Recreational drug use? ❑ Yes ❑ No Type: _____ Frequency: _____

Exercise? ❑ Yes ❑ No Type: _____ Frequency: _____

Caffeine? ❑ Yes ❑ No Type: _____ Amount per day: _____

Green or herbal tea? ❑ Yes ❑ No Type: _____ Frequency: _____

Smoking/Tobacco use? ❑ Yes ❑ No **If yes, please answer the following questions.**

1. Which of the following applies to you:

❑ Never Smoker ❑ Current Smoker ❑ Former Smoker ❑ Tobacco User

2. If you are a CURRENT SMOKER, please answer the following questions:

When did you start smoking: _____

How often do you smoke cigarettes?

❑ Every day ❑ Some days but not every day

How many cigarettes a day do you smoke?

❑5 or less ❑ 6-10 ❑ 11-20 ❑ 21-30 ❑ 31 or more

How soon after you wake up do you smoke your first cigarette?

❑ Within 5 minutes ❑ 6-30 minutes ❑ 31-60 minutes ❑ After 60 minutes

Are you interested in quitting?

❑ Ready to quit ❑ Thinking about quitting ❑ Not ready to quit

3. If you are a FORMER SMOKER, please answer the following:

When did you start smoking: _____ When did you stop: _____

How long has it been since you smoked?

❑ Less than 1 month ❑ 3-6 months ❑ 1-5 years ❑ Over 10 years

❑ 1-3 months ❑ 6-12 months ❑ 5-10 years

Are you a Tobacco "Other" user? ❑ Yes ❑ No Current or in the Past? (circle which)

If "Yes" - indicate type (pipe, tobacco, etc.) and frequency: _____

Alcohol? ❑ Yes ❑ No **If yes, please answer the following questions.**

1. Did you have a drink containing alcohol in the past year?
   ❑ Yes ❑ No
2. If "Yes": How often did you have a drink containing alcohol in the past year?
   ❑ Never ❑ Monthly or less ❑ 2 to 4 times a month
   ❑ 2 to 3 times per week ❑ 4 or more times a week
3. If "Yes": How many drinks did you have on a typical day when you were drinking in the past year?
   ❑ 1 or 2 ❑ 3 or 4 ❑ 5 or 6 ❑ 7 to 9 ❑ 10 or more
4. If "Yes": How often did you have six or more drinks on one occasion in the past year?
   ❑ Never ❑ Less than monthly ❑ Monthly ❑ Weekly ❑ Daily or Almost Daily

Review of Systems **Check if you are currently experiencing any of the following symptoms:**

Normal □ **1) Constitutional**

Fever	□
Weight Loss	□
Other	□ _____

Normal □ **2) Eyes**

Blurred Vision	□
Double Vision	□
Pain	□
Discharge	□
Other	□ _____

Normal □ **3) Ears, Nose, Mouth, Throat**

Pain	□
Mass	□
Discharge	□
Hearing Loss	□
Smell	□
Other	□ _____

Normal □ **4) Cardiovascular**

Chest Pain	□
Irreg. Heart Beat	□
Other	□ _____

Normal □ **5) Respiratory**

Short of Breath	□
Cough	□
Asthma	□
Other	□ _____

Normal □ **6) Gastrointestinal**

Bowel habits/change	□
Diarrhea	□
Constipation	□
Stomach Pain	□
Ulcers	□
Other	□ _____

Normal □ **7) Hematologic/Lymphatic**

Anemia	□
Blood Disease	□
Free Bleeder	□
Swollen Lymph Nodes	□
Other	□ _____

Normal □ **8) Musculoskeletal**

Weakness	□
Joint Pain	□
Decreased ROM	□
Other	□ _____

Normal □ **9) Integumentary (Skin/Breast)**

Masses	□
Tumors	□
Pigmented Lesions	□
Rash	□

Normal □ **10) Neurologic**

Weakness	□
Tingling	□
Numbness	□
Other	□ _____