

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

SSN: \_\_\_\_\_

**Secondary Insurance Company – Subscriber and Insurance Company Details**

Insurance Company: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

SSN: \_\_\_\_\_

**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.

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Signature of Patient or Legal Representative

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Date

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

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**PATIENT NAME**

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**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.

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

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**DATE**

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

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**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



<b>Family History:</b> Please check if your family has a history of the following conditions	<b>Diabetes</b>	<b>High Blood Pressure</b>	<b>Heart Disease</b>	<b>Stroke</b>	<b>Cancer</b>	<b>Mental Illness</b>	<b>Other</b>
<b>Father:</b> <input type="checkbox"/> Alive <input type="checkbox"/> Deceased Birth Year: _____ Age: _____							
<b>Mother:</b> <input type="checkbox"/> Alive <input type="checkbox"/> Deceased Birth Year: _____ Age: _____							
<b>Paternal Grandfather:</b> <input type="checkbox"/> Alive <input type="checkbox"/> Deceased Birth Year: _____ Age: _____							
<b>Paternal Grandmother:</b> <input type="checkbox"/> Alive <input type="checkbox"/> Deceased Birth Year: _____ Age: _____							
<b>Maternal Grandfather:</b> <input type="checkbox"/> Alive <input type="checkbox"/> Deceased Birth Year: _____ Age: _____							
<b>Maternal Grandmother:</b> <input type="checkbox"/> Alive <input type="checkbox"/> Deceased Birth Year: _____ Age: _____							
<b>Other:</b> _____ <input type="checkbox"/> Alive <input type="checkbox"/> 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:**

**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:**

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