PARK AVENUE
OCULOPLASTIC
SURGEONS

WELCOME TO OUR PRACTICE!

We are glad to welcome you to Park Avenue Oculoplastic Surgeons (PAOS) and Park Avenue Surgery Center (PASC). Enclosed are some materials which will acquaint you with our facilities, financial policies, and procedures.

We ask that you fill out the enclosed paperwork and bring it with you to your first appointment. Please make sure your medical history is accurate and complete.

- Include all information regarding the medications and vitamins you take, along with the dosage and frequency.
- Bring along your current insurance card and drivers license.
- Payment is expected at the time of service for all co-payments and non-contracted or cosmetic services and fees.

We are committed to exceeding each of our patients' needs and encourage you to let us know what we can do to best help you.

Please keep your scheduled appointment, or provide us with at least 24 hours' notice in the event that you need to cancel or reschedule to avoid paying the$50.00 cancellation fee.

You may visit our web site for more information and for directions to our office.

www.PAOSdenver.com

We look forward to seeing you very soon.

1800 Emerson St. Suite 200, Denver, CO 80218
Phone: 303-468-8844
www.PAOSdenver.com

PARK AVENUE OCULOPLASTIC SURGEONS

PATIENT DEMOGRAPHICS

Date_____

□ Mrs □Ms □Mr □Dr Legal Name: _____ Nickname: _____
Mailing Address _____
City:_____ State:_____ Zip Code:_____
Date of Birth:_____ SSN:_____
Marital Status:_____ Spouse's Name:_____
Primary Phone: _____ ( ) Home ( ) Work ( ) Cell
Secondary Phone: _____ ( ) Home ( ) Work ( ) Cell
Email address:_____ □ Exclude From Marketing
Occupation: _____ Place of Employment:_____

EMERGENCY CONTACT

Person to Notify: _____ Phone: _____
Relationship _____
If Patient is a child: Other Parent: _____ Phone: _____

REFERRAL INFORMATION

How Were You Referred to Our Office?_____
Referring Dr Address: _____ Phone _____
Referring Patient:_____
Reason for Appointment □ Functional □ Cosmetic _____

PRIMARY CARE PROVIDER

Provider Name:_____ Phone:_____
Address: _____
Other Specialist(s) You See (Cardiologist, Endocrinologist, Oncologist, Plastic Surgeon, Etc.):
Name _____ Specialty _____ Phone _____
Name _____ Specialty _____ Phone _____
Name _____ Specialty _____ Phone _____

PREFERRED PHARMACY

Name _____ Cross Streets _____ Phone _____

INSURANCE GUARANTOR

Primary Insurance_____ Subscriber Name: _____
Subscriber DOB:_____ Relationship: _____
Secondary Insurance: _____ Subscriber Name: _____
Subscriber DOB:_____Relationship _____

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CONFIDENTIAL MEDICAL HISTORY FORM

PATIENT NAME: _____ **DATE:** _____

1. Please list all <u>medications</u> you take on a regular basis:
(Include eye drops, vitamins, herbs, & over the counter products such as aspirin or aspirin containing products.)

	Medication	Strength/Dose	Frequency
1.			
2.			
3.			
4.			
5.			
6.			

2. Please list all <u>illnesses/diseases</u> which you have had or have now:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

3. Please list all prior <u>surgeries or procedures</u>:

	Surgery	Physician	Approximate Date
1.			
2.			
3.			
4.			
5.			

4. Please list any <u>allergy or sensitivity</u> to medication or food: ☐ **None**

	Medication	Reaction
1.		
2.		
3.		

Height_____ **Weight** _____

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PATIENT NAME: _____

5. HAS ANYONE IN YOUR FAMILY HAD THE SAME PROBLEM THAT BRINGS YOU TO OUR OFFICE?
[ ] Yes [ ] No If yes, who? _____

DO ANY OF THESE DISEASES RUN IN YOUR FAMILY? IF YES, PLEASE NOTE RELATIONSHIP

__Glaucoma _____
__Diabetes _____
__High blood pressure_____
__Skin cancer _____
__Other _____

Do you smoke? If YES, how much?
_____

Drink alcohol? If YES, how much?
_____

6. DO ANY OF THE FOLLOWING PROBLEMS APPLY TO YOU? IF YES, PLEASE EXPLAIN.

Constitutional (fever, weight loss, poor appetite, etc.)	□ yes □ no	
Eyes (Glaucoma, cataract, lazy eye, retina problems, etc.)	□ yes □ no	
Ear/Nose/Throat (hearing loss, sinus problems, sore throat, frequent bloody noses, etc)	□ yes □ no	
Cardiovascular (heart problems, chest pain, high blood pressure, stroke, pacemaker, heart surgery)	□ yes □ no	
Respiratory (asthma, shortness of breath, wheezing, coughing, etc)	□ yes □ no	
Gastrointestinal (heartburn, diarrhea, vomiting, abdominal pain, etc.)	□ yes □ no	
Genitourinary (urinary problems, blood in urine, etc)	□ yes □ no	
Skin (skin rashes, excessive dryness, used Accutane, skin cancer/diseases, etc.)	□ yes □ no	
Musculoskeletal (muscle aches, joint pain, swollen joints, artificial joint, arthritis, etc.)	□ yes □ no	
Neurological (numbness, weakness, paralysis, headaches, spasm, MS, etc.)	□ yes □ no	
Hematologic (blood disorders, leukemia, easy bleeding/bruising, take aspirin, etc.)	□ yes □ no	
Allergy (hay fever, seasonal allergies, etc.)	□ yes □ no	
Endocrine (thyroid or pituitary problems, etc.)	□ yes □ no	
Psychiatric (depression, anxiety, etc.)	□ yes □ no	
Hepatitis B or C, HIV or AIDS, Tuberculosis, etc.	□ yes □ no	
Diabetes, radiation treatments, anesthesia reactions, etc.	□ yes □ no	

Other Comments:_____

_____

Physician Initials Date:

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CANCELLATION/NO SHOW/FINANCIAL POLICY

1. Cancellation/ No Show Policy for Office Appointments

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

- ✓ **If my office appointment is cancelled within 24 hours of the scheduled time, I agree to pay a $50.00 fee. I understand this fee will not be covered by my insurance.**

2. Cancellation/ No Show Policy for Surgery

Due to the large block of time and professional staff needed for surgery, last minute cancellations can be problematic for surgery coordination and add expenses for the surgeon.

- ✓ **If my surgery is cancelled within 10 business days of the scheduled date, I agree to pay a $250.00 administrative fee. I understand this is fee will not be covered by my insurance.**

3. Financial Policy Account balances

We require that cosmetic/self-pay treatments be paid in full prior to services rendered. Account balances assessed to patient responsibility by third party payers must be paid in full or arrange a payment plan prior to receiving further services from our practice.

Patients who have questions about their bills or who would like to discuss options for payment plans may call and ask to speak to our Patient Financial Coordinator with whom they can review their account and concerns.

- ✓ **Checks returned for non-sufficient funds or other reasons will result in an additional charge of $35 for re-processing.**
- ✓ **In case of default payment, I agree to pay any and all costs of collecting this account including but not limited to a collection fee of 40%, attorney fees and court costs.**

_____
PATIENT NAME

_____ _____
SIGNATURE DATE

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HIPPA POLICY & NOTICE

At Park Avenue Oculoplastic Surgeons (PAOS), we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, how and when we use and disclose of that information. It also describes your rights as they relate to your protected health information. This Notice is effective March 1, 2003 and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record Information

Each time you visit PAOS, a record of your visit is made. Typically this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication amongst the many health professionals who contribute to your care
- Legal document describing the care you received
- Means by which you or a third party payer can verify that services billed were actually provided
- A tool in educating health professionals
- A source of data for medical research
- A source of information for public health officials charged with improving the health of this state and nation
- A source of data for our planning and marketing
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, where and why others may access your health information, and make more informed decisions when authorizing disclosures to others.

Your Health Information Rights

Although your health record is the physical property of PAOS, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request
- Receive a copy your health record as provided for in 45 CFR 164.524
- Amend your health record as provided for in 45 CFR 164.528
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
- Request communications for your health information by alternative means or at alternative locations
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

PAOS is required to:

- Maintain the privacy of your health information
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice

PATIENTSIGNATURE(OR AUTHORIZED REPRESENTATIVE) DATE

NAME

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INSURANCE BILLING AGREEMENT

BY SIGNING BELOW I AGREE TO THE FOLLOWING:

- I authorize Park Avenue OculoPlastic Surgeons, PC (PAOS) and/or Park Avenue Surgery Center, LLC (PASC) to give me reasonable and proper medical care by today's standard.
- I understand that all charges are payable on the day service is rendered if not covered by insurance.
- **I understand it is my responsibility to verify with my insurance carrier that my provider at PAOS is participant of my insurance plan.**
- I authorize PAOS/PASC to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner.
- I understand that my contract is between PAOS/PASC and myself.
- I authorize PAOS/PASC to release any medical or other necessary information that my insurance carrier may require concerning my personal health information in either paper or digital from.
- I agree to assign all payments for all services rendered to PAOS/PASC.

_____ _____

PATIENT SIGNATURE DATE

_____

PRINTED NAME

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