NOTICE OF PRIVACY PRACTICES

To our patients: This notice describes how health information about you, as a patient of this practice, may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your health information
- Your privacy rights
- Our obligations concerning the use and disclosure of your health information

We may use and disclose your health information in the following ways

- **Treatment:** Physicians and staff may use or disclose your health information in order to treat you or to assist others in your treatment. Additionally, we may disclose your health information to others who may assist in your care, such as your spouse, children, or parents.
- **Payment:** Our practice may use our health information to bill and collect payment for the services you receive from us. We may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose this information to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your health information to bill you directly for services and items.
- **Health care operations:** We may need to use and disclose your health information to be able to run our practice at the highest clinical standards and effectively as possible. This could be used to evaluate the performance of our physicians and staff, to determine if our treatment plans are effective, or determine if ther are other services we should be offering. We may also compare our clinical data with other practices, review it with medical students, medical faculty, technicians, and others for educational purposes. We will strive to remove information that identifies you from this medical information.
- **Disclosures required by law:** Our practice will use and disclose your health information when we are required to do so by federal, state, or local law.
- **Appointment Reminders and Sign-In Sheets:** We may want to call you by phone for reminder purposes and leave a message on your answering machine at home, work, or with a family member.

  We will also use a sign in sheet at the front desk for purposes of logging our patients as the arrive. We will require you name only on this sign in sheet.

  Oculoplastic Consultants of Arizona may conduct patient group educational sessions for our patients. Specific questions relating to your individual medical issues will be addressed in private.

  You can request that our practice communicate with you about your health and related issues in a particular manner. For instance, you may wish to be contacted at work during business hours rather than home. We will accommodate reasonable requests. We will enlist the help of a translator (including ASL) if needed. This person may be your own family member, neighbor, or friend who accompanies you. This person could be privy to some of your health information.

  You can request a restriction in our use or disclosure of your health information for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in our care or the payment for our care, such as family members and friends. We are not required to agree to your

request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

Any restrictions must be given to Oculoplastic Consultants of Arizona in writing.

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

- To public health authorities and health oversight agencies that are authorized by law to collect information.
- Lawsuits and similar proceedings in response to court or administrative order.
- If asked to do so by a law enforcement official.
- When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
- If you are a member of the U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
- To federal officials for intelligence and national security activities authorized by law.
- To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
- For Workers Compensation and similar programs.

Your rights regarding your health information

- Communications. You can request that our practice communicate with you about your health information and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than at work. We will accommodate reasonable requests.
- You can request a restriction in our use or disclosure of you health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
- You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request to our office in writing.
- You may ask us to amend your health information if you believe it is incorrect or incomplete, as long as the information is kept by or for our practice. To request an amendment, your request must be submitted in writing to our office. Our practice has 60 days to respond to your request.
- Right to a copy of this notice. You are entitled to receive a copy of this notice of privacy practices.
- Right to file a complaint. If you believe you privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. Submit your written complaint to the address listed below.
- Right to provide authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. This authorization stays in effect until you revoke it.

If you have any questions about our privacy policies or wish to submit written requests, contact us at:

Oculoplastic Consultants of Arizona **Tel: (602) 993-9100**
20100 N. 51st. Avenue, Ste. E570
Glendale, AZ 85308

Oculoplastic Consultants of Arizona

PATIENT REGISTRATION

Mr. Mrs. Ms. Miss. Legal Name: ______________________________
Last First MI

Spouse: ______________________________

Permanent Address: ______________________________
Street Apt# City State Zip

Local Address: ______________________________
Street Apt# City State Zip

Email Address: ______________________________

Telephone: home ____________ work ____________ cell ____________

Sex (circle one) M F Age: ________ Date of Birth: _____ / _____ / _____ Social Security#: ____________

Responsible Party: ____________ Phone: ____________ Relationship: ____________

Name & Address of Employer: ______________________________

Occupation: ______________________________

Emergency Contact: ____________ Phone: ____________
(other than spouse)

Name of Medical Doctor: ______________________________

Address: ____________ Phone: ____________

Insurance Information

Primary Insurance: ____________ Policy Holder: ____________

Group#: ____________ Policy#: ____________ D.O.B. ____________

Policy Holder's social security # ______________________________

Insurance Address: ____________ Insurance Phone: ____________

Secondary Insurance: ____________ Policy Holder: ____________

Insurance Address: ____________ Insurance Phone: ____________

Group#: ____________ Policy#: ____________

Pharmacy Information:

Name of Pharmacy: **Telephone Number:**

Address or Cross Streets:

Referred by: ______________________________

Patient Medical History

Thank you for completing this form. This information will assist your doctor and staff in providing quality care

Dr. Mr. Mrs. Ms. Miss: ________________________________ Age ______ Date______________________
(circle one)

Medical History: Do you have or have you had:

Lung	Yourself		Family History
Asthma	Yes__	No__	__
Emphysema	Yes__	No__	__
Pneumonia	Yes__	No__	__
Chronic bronchitis	Yes__	No__	__
Use oxygen at home?	Yes__	No__	__
Sleep apnea	Yes__	No__	__

General			
Anemia	Yes__	No__	__
Bleeding disorder	Yes__	No__	__
Sickle Cell	Yes__	No__	__
Clotting disorders	Yes__	No__	__
Diabetes	Yes__	No__	__
Thyroid	Yes__	No__	__
Sleep apnea	Yes__	No__	__
Kidney disease/dialysis	Yes__	No__	__
Liver disease/cirrhosis	Yes__	No__	__
Chronic muscle weakness	Yes__	No__	__

Cardiovascular	Yourself		Family History
Congestive heart failure	Yes__	No__	__
Chest pain/angina	Yes__	No__	__
Heart attack	Yes__	No__	__
Heart valve problems	Yes__	No__	__
Abnormal heart rhythm	Yes__	No__	__
Pacemaker/defibrillator	Yes__	No__	__
Poor circulation to legs	Yes__	No__	__
Stroke/TIA	Yes__	No__	__
Hypertension	Yes__	No__	__

Other			
Cancer	Yes__	No__	__
Glaucoma	Yes__	No__	__
Cataracts	Yes__	No__	__
HIV/AIDS	Yes__	No__	__
Immunodeficiency	Yes__	No__	__
Seizure	Yes__	No__	__

Any other diseases, conditions or problems we should know about?

____

____

Surgery History: List **ALL** prior surgeries with years:

____

____

____

____

Eye surgeries: ____

____

Have you had problems with anesthetics? Yes__ No__

If yes, what was the problem? ____

Has anyone in your family had a problem with an anesthetic? Yes__ No__

Social History:

Do you smoke? Yes__ No__ How many packs per day? __ For how many years? __

Alcoholic beverage use Yes__ No__

Social drug use Yes__ No__

Medications: Medications you are currently taking including over-the-counter medicines or home remedies (including herbal supplements, diet pills and blood thinners such as aspirin)

Drug Name	**Strength**	**How often used**

Allergies: (if no allergies put "NONE")

Medications: ____

Foods, soaps: ____

Are you sensitive to Iodine? Yes__ No__ Tape? Yes__ No__ Latex? Yes__ No__

Oculoplastic Consultants of Arizona, P.C., Financial Policy & Privacy Practices

Thank you for choosing Oculoplastic Consultants of Arizona as your Oculoplastic Specialist. Please carefully review our financial policy, initial by each item and sign below.

___**Consultation fees:** This fee is $350, and does not include laboratory fees, procedural fees, medical supplies, administrative fees, radiologic, pathologic, and photographic or medication charges. They pertain only to your consultation with the physician.

___**Cosmetic Consultation:** There is a $350 fee for a cosmetic consultation, which is credited toward your surgery fees. If you decide to schedule surgery at a later date, the credit can be applied toward the surgical fee for up to 6 months.

___**Insurance payments:** Your insurance policy is a contract between you and your insurance company. It is your responsibility to know and understand the details of your insurance coverage. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. If your insurance company does not pay within a reasonable time period, Oculoplastic Consultants of Arizona, P.C., will look to you for payment. If you elect to receive your insurance benefits directly, or if you do not have health insurance, you will be responsible for paying for your visit in full, at the time of service.

___**Copayments and deductible amounts:** will be collected at the time of your visit.

___**Authorizations and referrals:** If your insurance requires a referral or authorization, it is your responsibility to be sure that our office has this information, or bring it to your appointment personally.

___**Change of insurance plan:** It is your responsibility to notify us of any changes in your insurance coverage at the time you check-in for your appointment. Failure to notify us of any insurance changes may result in charges for which you will be held responsible.

___**Non-covered procedures:** At times, your insurance may not cover certain procedures or tests that are necessary for your care, such as external photography or visual field testing. In the event that this may occur, you will be responsible for the cost of such tests or procedures.

___**Minors (patients younger than 18 years old):** An adult or legal guardian must accompany all minors to their office visit. A signed authorization to treat a minor is also acceptable as well. The adult or legal guardian accompanying the minor assumes all financial responsibility for the cost of the minor's visit. Our office does not accept any third party assignments nor do we recognize or enforce any divorce decrees.

___**Returned check fee:** There is a $35 service fee on each returned check. An NSF check must be redeemed with cash or a certified form of payment such as money order, cashier's check, or a certified bank check.

___**Delinquent accounts** will be forwarded to a credit reporting agency and/or a collection agency. You will also be responsible for all fees including but not limited to collection fees, attorney charges, and court fees incurred by Oculoplastic Consultants of Arizona, P.C. Interest at 10% (APR) per annum will be applied toward your balance after 60 days.

___**No show fee:** Due to the high demand for appointments, a missed appointment prevents other patients in need of urgent care from receiving timely treatment. **Please notify the office at least 24 hours in advance** if you need to cancel or reschedule your appointment. Otherwise, you will be subject to a **$25 no-show fee**. <u>Your insurance plan does not cover this fee.</u>

___**Surgery fees:** Should you require an operation, you will be billed separately for anesthesia and surgery center facility fees. Your surgery scheduler will cover this in detail when you schedule surgery. Please be sure to contact your anesthesiologist and surgery center to verify that they are on your insurance plan.

I have read the above financial policy and agree to abide by the terms of this policy. I also acknowledge that I have been presented with a copy of the Notice of Privacy Practice

X____

Signature of patient (or parent if minor) Date

Oculoplastic Consultants of Arizona, P.C., Surgery Financial Policy

Thank you for choosing Oculoplastic Consultants of Arizona as your Oculoplastic Specialist. Before you schedule surgery it is important that you understand your financial responsibilities. Please carefully review our financial policy, initial by each item and sign below.

__Cosmetic Consultation: There is a $350 fee for a cosmetic consultation, which is credited toward your surgery fees. If you decide to schedule surgery at a later date, the credit can be applied toward the surgical fee for up to 6 months.

__Cosmetic surgery payments: payment in full is required at least 2 weeks prior to surgery if paid by check, and 1 week prior to surgery if paid by cash or credit card. We do not participate in any financing programs.

__Insurance payments: Your insurance policy is a contract between you and your insurance company. It is your responsibility to know and understand the details of your insurance coverage. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. If your insurance company does not pay within a reasonable time period, Oculoplastic Consultants of Arizona, P.C., will look to you for payment. If you elect to receive your insurance benefits directly, or if you do not have health insurance, you will be responsible for paying for your visit in full, prior to the date of surgery.

__Authorizations, notifications or predeterminations: Your insurance may require a prior authorization, notification of procedure, or predetermination for your surgery. **In most instances, this does not guarantee payment, but simply verifies that the benefits are available.** The insurance company reserves the right to review all documentation after the service is performed, and at then determines whether the charges will be paid.

__Copayments and deductible amounts associated with your surgery are your responsibility.

__Change of insurance plan: It is your responsibility to notify us of any changes in your insurance coverage at the time you check-in for your appointment. Failure to notify us of any insurance changes may result in charges for which you will be held responsible.

__ Additional charges: you will be billed separately for the use of the surgery center, anesthesiologist, and pathologist.

__Surgery cancellation: because surgical appointments are in high demand, cancellation of surgery without advance notice, denies other patients the opportunity to have surgery. Therefore, a **fee will be assessed in the event of a surgery cancellation without 2 WEEKS advance notice. For cosmetic patients, the amount is 15% of the total charge, and for insurance patients, the fee is $250.00. This fee is not covered by your insurance.**

__Preoperative labwork: most patients who have surgery performed in a hospital or ambulatory surgery center will require routine preop labwork and an EKG. It is your responsibility to complete your testing in a timely manner so that your physicians will have the opportunity to review the results and take corrective action if needed. **Failure to do so will result in cancellation of your surgery and assessment of the surgery cancellation fee (see above).**

I have read the above financial policy and agree to abide by the terms of this policy.

X____

Signature of patient (or parent if minor)

Oculoplastic Consultants of Arizona, P.C., Surgery Financial Policy

OCULOPLASTIC CONSULTANTS OF ARIZONA TOUCH UP POLICY

DEFINITION OF A TOUCH UP:
A procedure required to improve a recently performed surgery with some remaining residual effects. Some examples would be excising a mild amount of remaining excess skin after an upper lid blepharoplasty, excising a mild amount of residual excess fat after a lower lid blepharoplasty, or to correct asymmetry after a brow ptosis repair. A touch up is only done for patients who had previous surgery with Dr. Chen or Dr. Pharo, not with other doctors.

A touch up does not include:

- Doing another surgery to correct some finding that was not attempted to be corrected during the first surgery. An example would be doing a lower lid skin removal when only the fat was excised during a lower lid blepharoplasty, or correcting brow droop if only a blepharoplasty was performed.

COSMETIC TOUCH UP COSTS:

- 0 to 6 months: no charge for touch up
- 6-12 months: 1/3 cost of original surgery
- >1 year: full price

FUNCTIONAL TOUCH UP COSTS:

- 0-6 months: $500 per eyelid
- 6-12 months: 1/3 cost of the desired cosmetic procedure
- >1 year: full price cosmetic

I have read the above financial policy and agree to abide by the terms of this policy.

X____
Signature of patient (or parent if minor)