

PLASTIC EYE SURGERY ASSOCIATES, PLLC

James R. Patrinely, MD, FACS

Charles N.S. Soparkar, MD, PHD, FACS

3730 Kirby Drive, Suite 900, Houston, TX 77098

Telephone (713) 795-0705 / FAX (713) 807-0630

Dear Patient:

Welcome to our office. We feel privileged that you have sought us out for consultation.

We specialize exclusively in aesthetic and reconstructive surgery around the eyes, and people are referred to us from across the globe with what are sometimes very complicated problems. In order to meet the demand to provide the very best advice and care, we have developed a unique, collaborative practice pattern.

Dr. Patrinely and Dr. Soparkar are all highly trained, widely recognized, and broadly published oculoplastic surgeons. They have joined together in an unusual, interactive, and cooperative fashion, merging slightly different areas of super-specialized expertise. You have scheduled to see one physician, but depending upon the complexity of your problem and the office schedule, you may be examined by several, potentially providing you with more than one perspective and opinion. If this occurs, your insurance will be billed for only one examination.

In our office, you may also encounter other physicians. At any given time, we may be training up to 3 other doctors from around the world. These are exceptional physicians who have already completed 4 – 5 years of specialized medical training and have been carefully selected for further tutelage. You may find their opinions valuable as well.

Should you require surgery, be assured that your physician (Dr. Patrinely or Dr. Soparkar) will perform your procedure himself, but some of the more complicated procedures require two pairs of skilled hands, and your physician may ask a partner to assist.

We hope that you will think of Dr. Patrinely and Dr. Soparkar as your physicians. They are often called emergently to provide assistance or advice to other doctors in the medical center, and there may be occasions that your physician will be called away, requiring the other partner to cover office visits. We will inform you of such events with as much notice as possible. If, for any reason, you find that you strongly prefer one physician to the other, please notify our staff, and we will make every effort to meet your needs.

Again, thank you for offering us the privilege to assist you. Please take this opportunity today to gain as much information and advice from your visit as you can. The more you know, the better equipped you will be to make important decisions about your health and care, and the more you can help us to help you.

DATE: _____

PERSONAL REGISTRATION INFORMATION

PLEASE PRINT CLEARLY

PATIENT INFORMATION

NAME: _____ AKA: _____ DATE OF BIRTH: _____

SOCIAL SECURITY NUMBER: _____ M/F: _____ MARITAL STATUS: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

OCCUPATION/EMPLOYER: _____ DRIVERS LICENSE NO.: _____

GUARANTOR

NAME: _____ RELATIONSHIP: _____

SOCIAL SECURITY NUMBER: _____ M / F: _____ MARITAL STATUS: _____

ADDRESS (IF DIFFERENT) _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORK PHONE: _____ EMPLOYER: _____

EMERGENCY CONTACTS

NAME: _____ PHONE #1: _____ PHONE #2: _____ RELATION: _____

NAME: _____ PHONE #1: _____ PHONE #2: _____ RELATION: _____

INSURANCE

PRIMARY INSURANCE CO: _____ PHONE NO: _____

INSURED NAME: _____ INSURED DOB: _____ SS#: _____

PLAN TYPE: _____ GROUP #: _____ INSURED ID#: _____

INSURED DRIVERS LICENSE NO.: _____ RELATIONSHIP TO PATIENT: _____

SECONDARY INSURANCE CO: _____ PHONE NO: _____

INSURED NAME: _____ INSURED DOB: _____ SS#: _____

PLAN TYPE: _____ GROUP #: _____ INSURED ID#: _____

INSURED DRIVERS LICENSE NO.: _____ RELATIONSHIP TO PATIENT: _____

INFORMATION SHARING

NAME: _____

DATE: _____

HOW MAY WE CONTACT YOU?

HOME PHONE: _____ EMERGENCY ONLY ROUTINE OK TO LEAVE DETAILED MESSAGES

WORK PHONE: _____ EMERGENCY ONLY ROUTINE OK TO LEAVE DETAILED MESSAGES

CELL PHONE: _____ EMERGENCY ONLY ROUTINE OK TO LEAVE DETAILED MESSAGES

EMAIL **: _____ EMERGENCY ONLY ROUTINE OK TO LEAVE DETAILED MESSAGES

OTHER: _____ EMERGENCY ONLY ROUTINE OK TO LEAVE DETAILED MESSAGES

****The more available you are to us, the more quickly we can provide you with important scheduling changes, visit reminders, laboratory results, peri-operative instructions, answers to your questions, etc.**

REFERRAL

Who referred you to our practice?

NAME: _____

May we contact them? YES NO

LEGAL GUARDIAN

If you have appointed a legal guardian for your health and financial issues, please tell us who that is.

Guardian's Name: _____

PHYSICIANS / HEALTH CARE PROVIDERS

We believe it is in your best interest for us to know all the health care providers involved in your care, so that we may communicate relevant information in a timely fashion. Please list below all of your regular physicians and health care providers (including complimentary health care providers such as chiropractor, naturopath, dietician, and acupuncturist) with whom you are willing for us to communicate.

PROVIDER'S NAME	SPECIALTY	TELEPHONE NUMBER

FRIENDS AND FAMILY

Your privacy is very important to us. We can not share any information (including confirming appointment date and time) with anyone, including a spouse or care-giving child (unless they are your legal guardian) without your express permission. Please list below all persons with whom you will allow us to fully discuss your medical issues.

INDIVIDUAL'S NAME	RELATIONSHIP	TELEPHONE NUMBER

GUARDIAN SIGNATURE: X _____ PATIENT SIGNATURE X _____

NAME: _____

DATE: _____

Height: _____ Weight: _____

MEDICAL PROBLEM LIST

Please circle all current and significant past medical problems and explain below.

HEART

- Heart attack / heart failure
- Irregular heart rhythm
- Chest pain
- High blood pressure
- High cholesterol
- Pacemaker

BREATHING

- Asthma
- Trouble breathing
- Lung infections
- Lung disease

ENDOCRINE

- Thyroid disease
- Diabetes
- Heat/cold intolerance

GENITOURINARY

- Kidney or prostate disease
- Trouble urinating
- Sexually transmitted disease

GENERAL HEALTH

- Fever
- Fatigue or low energy
- Night sweats or chills
- Weight gain/loss
- Ankle swelling

PSYCHIATRIC

- Depression / mood swings
- Anxiety
- Confusion
- Poor memory
- Drug addiction

CANCER / BLOOD

- Cancer
- Radiation treatment
- Chemotherapy
- Anemia (low blood)
- Excessive bruising
- Swollen glands

ALLERGY / IMMUNE

- Hay fever
- Frequent infections
- HIV positive
- Autoimmune disease

SKIN / BREAST

- Skin cancers
- Rashes
- Breast lumps or pain

EAR, NOSE, THROAT

- Sinus problems
- Hearing problems
- Hoarseness
- Frequent nose bleeds

NEUROLOGIC

- Severe or frequent headaches
- Stroke
- Seizures
- Parkinson's disease
- Paralysis

GASTROINTESTINAL

- Reflux
- Indigestion
- Bloody / tar-colored stool
- Ulcer disease
- Hepatitis
- Liver disease

EYE

- Irritation, itching, burning, or pain
- Tearing
- Blurry vision
- Blindness
- Eye swelling

MUSCULOSKELETAL

- Joint pain
- Pain when chewing
- Muscle cramps
- Weakness
- Arthritis

OTHER

Please Explain Your Significant **MEDICAL PROBLEMS, SURGERIES & HOSPITALIZATIONS:**

Please list **DISEASES** that run in your **FAMILY:**

Do You **Smoke?** Y / N Did you **EVER?** Y / N How many packs /day? _____ How many years? _____
Do You Drink **Alcohol?** Y / N How many drinks / day? _____

Important Information for Patients taking Blood-thinning Medication

Blood-thinners ("anticoagulants"), such as aspirin, Coumadin, Plavix, and Lovenox are powerful medications prescribed to prevent life-threatening blood clots responsible for heart attacks, brain strokes, lung strokes, and deep vein thrombosis.

However, bleeding is a potential complication of any surgery, and people taking blood-thinners around the time of their procedure or who have poorly controlled high blood pressure are at increased risk for developing bleeding and associated complications, such as increased bruising, surgery failure, and even vision loss or blindness.

But, if you stop taking your blood-thinner(s) before surgery to lessen the chance of bleeding, you increase your risk for developing life-threatening blood clots.

Thus, if you are on blood-thinners and wish to have surgery, you must accept the increased risk of one or the other of these complications — blood clots or bleeding.

Your surgeon and your primary doctor/cardiologist can offer you advice about the relative risks and benefits of stopping or continuing your blood-thinners around the time of your surgery. If you have not already obtained such advice, you may wish to do so.

Importantly, there are many other prescription and non-prescription medications and supplements which also affect your clotting and bleeding. A partial list has been provided in your surgery packet.

Note: If you are taking blood-thinners, even if you decide to stop these for your surgery, you should NOT take the anti-bruising vitamins we offer.

In the event that I am taking blood thinners (such as aspirin, Plavix, Coumadin, such as Lovenox) around the time of any surgery, I understand that stopping these medicines before surgery may increase my risk of a having a heart attack, stroke or other life-threatening blood clots. I also understand that if I continue my blood-thinners through surgery, I have an increased risk of bleeding complications that could result, in rare cases, in vision loss or blindness.

Print Patient Name

Patient Signature

Date

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CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I consent to the use or disclosure of my protected health information by Plastic Eye Surgery Associates, PLLC for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Plastic Eye Surgery Associates, PLLC. I understand that diagnosis or treatment of me by James R. Patrinely, MD or Charles N.S. Soparkar, MD, PhD may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Plastic Eye Surgery Associates, PLLC is not required to agree to the restrictions that I may request. However, if Plastic Eye Surgery Associates, PLLC agrees to a restriction that I request, the restriction is binding on Plastic Eye Surgery Associates, PLLC and James R. Patrinely, MD or Charles N.S. Soparkar, MD.

I have the right to revoke this consent, in writing, at any time, except to the extent that James R. Patrinely, MD, Charles N.S. Soparkar, MD, PhD, or Plastic Eye Surgery Associates, PLLC has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and

created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me. I understand I have the right to review Plastic Eye Surgery Associates, PLLC's Notice of Privacy Practices prior to signing this document. The Plastic Eye Surgery Associates, PLLC's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Plastic Eye Surgery Associates, PLLC. The Notice of Privacy Practices for Plastic Eye Surgery Associates, PLLC is also provided in the clinic hallway. This Notice of Privacy Practices also describes my rights and the Plastic Eye Surgery Associates, PLLC's duties with respect to my protected health.

Plastic Eye Surgery Associates, PLLC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing the Plastic Eye Surgery Associates, PLLC's website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative _____

Name of Patient or Personal Representative _____

Date _____

Description of Personal Representative's Authority _____

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FINANCIAL POLICY

Thank you for selecting Plastic Eye Surgery Associates, PLLC (PESA) for your care. To prevent any confusion over financial responsibility for medical and surgical services provided, we supply you with the following information:

The patient, guarantor, or the person bringing the patient (if the patient is a minor), is responsible for payment of services at the time of office visit, test, or procedure. Payment may be made by cash, personal check (NSF charge: \$25), or credit card (American Express, Discover, VISA, or MasterCard). In the case of divorced parents, the parent bringing the child to the office is responsible for payment at the time of service. Bills provided at each visit contain all the information needed for you to submit requests to your insurance carrier.

If your insurance plan requires a referral from your primary care physician, it is your responsibility to bring the referral with you and present it at the registration desk

at the time of your visit. Federal law and insurance contracts require us to ask for your insurance card and driver's license at check in for identification purposes.

PESA CONTRACTED INSURANCE COVERAGE

If you have coverage through an insurance company that has a contract with the doctor you are seeing, we are required to ask for copy of your insurance card and payment of your deductible and/or co-payment at the time of service.

NON-PESA CONTRACTED INSURANCE COVERAGE

If you have coverage through an insurance company that does not have a contract with the doctor you are seeing, we will ask for a copy of your insurance card but payment for services may be due at the time of your visit. We will be happy to communicate with your insurer to possibly provide covered care.

MEDICAID

If you have Medicaid coverage, you must provide a current Medicaid card at the time of your visit. If the card is not available, you must either pay for the visit or reschedule the appointment. If within three months after the visit you receive a retroactive card that covers the date of the visit, payment will be refunded after Medicaid has paid for your visit. You must pay for non-covered services at the time of your visit.

MEDICARE

Office visits to a doctor are covered under Part B of the Medicare program. Medicare pays 80% of their allowable charges after you pay the annual deductible for the calendar year. You are fully responsible for any non-covered services. As a courtesy, if you have supplemental insurance, we will be glad to file this for you.

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"I have read the above information and agree that regardless of insurance status, I am responsible for the account balance for all services rendered to the individual listed as "patient" below including disclosed, non-covered medical services. Further, I irrevocably assign and transfer all health plan and insurance benefits to Plastic Eye Surgery Associates, PLLC (PESA), authorizing payment to PESA for all benefits payable to "patient" including health plan benefits, ERISA benefits, insurance payments, payments pursuant to the Social Security Act and other medical benefits to which "patient" may be entitled. PESA may pursue collection of such benefits in "patient's" name or in the name of PESA. Finally, I authorize the release of any medical information necessary to process "patient's" claims. A photocopy of this agreement shall be considered as effective and valid as the original."

Patient's Name (please print) :

Date:

Patient's Signature: X

If applicable, Signature of guardian or responsible party: X

Printed Name of guardian or responsible party:

PLASTIC **EYE** SURGERY ASSOCIATES, PLLC
PAYMENT POLICY

Thank you for choosing our practice to help with your surgical needs. The following policy has been developed to be fair to everyone including you, other patients waiting for surgery, anesthesiology staff who take time off from their regular full-time hospital-appointed positions, our office staff, and your surgeon.

DEPOSIT

For cosmetic procedures, a **\$500 deposit** is required at the time of scheduling. If procedure is cancelled or rescheduled within 14 business days prior to your surgery date, unless we are able to fill this spot, this deposit becomes non-refundable.

Initial

For insurance-covered procedures, a **\$50 deposit** is required at the time of scheduling. If cosmetic procedures are being performed at the same time, a total deposit of only \$300 is required. If procedure is cancelled or rescheduled within 14 business days prior to your surgery date, unless we are able to fill this spot, the deposit is non-refundable.

Initial

For Facial Fillers, (Restlane/Perlane/Juvederm) injections, a **\$100 deposit** is required at the time of scheduling. If appointment is cancelled or rescheduled within 48 hours, the deposit is non-refundable.

Initial

RESCHEDULING

We understand events may arise which may make it impossible for you to keep your surgery appointment. Please communicate all cancellations directly to our Surgery Scheduler, or our office Manager, **Ms. Broussard**. Please give us as much notice as you can. Depending upon whether we have enough notice to fill your spot and/or whether significant insurance-covered or hospital-based procedure leg-work needs to be duplicated, a repeat deposit may be required to reschedule your procedure.

Initial

PAYMENT DUE

Full payment of your responsibility for surgery is required at least five (5) working days in advance of all elective surgery. For insurance-covered procedures, we will provide you with our very best **estimate** based upon anticipated procedures and the most current fee schedules provided by your insurance company. If you are using an anesthesiologist in our office, then full payment for this service is required five (5) working days before your surgery as well.

If you decide you would like to use a different credit card, than the one used at time surgery was scheduled, you will need to contact us 10 days prior to surgery or risk an additional 9% processing fee.

Initial

CREDIT CARD PAYMENTS

We are happy to accept credit card payment at no additional charge to you. However, if you must cancel or reschedule your surgery *and you require a refund processed on your credit card*, then we must pass along to you a nine percent (**9 %**) **processing fee** to cover state franchise taxes and the intermediary charges.

Patient's Name

Patient's Signature

Date Signed

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PERMISSION FOR PHOTOGRAPHS

I hereby grant permission to Plastic Eye Surgery Associates, PLLC (referred hereafter as PESA) to take photographs of me and my medical or cosmetically relevant condition for any or all of the following uses:

- 1.) Facilitate telephone conversations with PESA physicians regarding my condition.
- 2.) Documentation of any changes in my situation.
- 3.) Documentation for insurance purposes of medically necessary concerns.

In addition, I understand that such photographs, or portions thereof so cropped as to aid in masking my identity, may be used for teaching or clinical research purposes in either lecture or publication format without any remuneration to me. By signing this form I release the medical practice of PESA from any future claims as well as liability arising from the use of said photographs, understanding that to protect my privacy, un-masked, full-face photographs will NOT be used in publication, unless I provide additional written consent.

Any photographs taken by PESA remain the express property of PESA as part of my medical record. Although, like the remainder of my medical record, I have legal right to obtain copies of the same upon written request in keeping with usual state and federal laws and PESA policies.

Signature _____ **Date** _____

Patient Name (Print) _____



Acknowledgment of Receipt

PLASTIC **EYE** SURGERY ASSOCIATES, PLLC

By signing this form, you are agreeing that you have received a copy of the Plastic Eye Surgery Associates, PLLC Privacy Notice, which describes how we use and disclose your health information. You have the right to refuse to sign this Acknowledge, in which case we must document our good faith effort to obtain your acknowledgment and the reason why it was not obtained.

Receipt of Privacy Notice acknowledged by:

Signature

Date

Print Name

Relationship to patient:

Self Other: _____

Patient, spouse, legal representative, or beneficiary (Patient's spouse may authorize disclosure of patient's health information only when the health information is for the sole purpose of processing an application for health insurance, for enrollment in a health care service plan or any employee benefit plan, and patient is to be an enrolled spouse or dependent under the policy or plan.