ELITE OCULOPLASTIC SURGERY

Michelle H. White, MD

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT AND CONSENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information.

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly/indirectly.
- Obtain payment form third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient _____

Signature _____ Date _____

OFFICE USE ONLY

I attempt to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date:	Initials:	Reason:

Elite OculoPlastic Surgery
Michelle H. White, MD

Please fill out form completely. Mark N/A or draw a line through the field if it doesn't apply.

Patient Name _____ **Date of Birth** _____

Mailing Address _____

City_____State _____ Zip Code _____SS# _____

Telephone:Home _____ Cell_____ Can we leave a Message Y / N

Email address: _____

Occupation:_____Preferred Contact Method_____

EMERGENCY INFORMATION

Person to Notify _____Relationship_____

Telephone: Work/Home/Cell_____

If Patient is a child: Father Name_____ Telephone Home_____Work_____

Mother Name_____ Telephone Home_____Work_____

REFERRAL INFORMATION

Who sent you to our office? _____ Telephone_____

Address_____ Fax _____

Reason for appt (eyes, face, skin care) ☐ Functional ☐ Cosmetic

PHYSICIAN INFORMATION

GeneralMD_____Telephone _____

Address_____City:_____State:_____ Zip:_____

Other Specialist Doctors (eye, glasses, cardiology, endocrine, cancer, plastic surgery, etc):

Ophthalmologist _____ M.D. Telephone _____

Optometrist _____ O.D. Telephone _____

Name _____ Specialty _____ Telephone _____

INSURANCE INFORMATION Please have insurance cards and ID/Driver's License ready to scan

Primary Insurance _____Subscriber _____

Subscriber Date of Birth_____ Subscriber SSN# _____

Patient's Relationship to Subscriber _____

Secondary Insurance _____

Subscriber name _____Subscriber DOB _____

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PATIENT NAME: _____ DATE: _____

1. Please list all medications you take on a regular basis:
(Please include any eye drops, vitamins, herbs, or over the counter products such as aspirin or aspirin containing products.)

Medication	Strength/Dose	Frequency
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

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

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

3. Please list all prior surgeries or procedures:

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

4. Please list any allergy or sensitivity to medication or food: None☐

Medication	Reaction
1.	
2.	
3.	
4.	
5.	

Height_____ **Weight** _____

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 _____
__Heart Disease _____
__High blood pressure _____
__Skin cancer _____
__Other _____

Do you smoke? Y / N
If YES, how much_____

Drink alcohol? Y / N
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	
Cardiovasc (heart problems, chest pain, high blood pressure, stroke, pacemaker, heart surgery)	□ yes □ no	
Respiratory (asthma, shortness of breath, wheezing, coughing, etc)	□ yes □ no	
Gastro-intestinal (heartburn, diarrhea, vomiting, abdominal pain, etc)	□ yes □ no	
Genito-urinary (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 problems, etc.	□ yes □ no	

Other Comentents: _____

Physician Initials _____ Date _____

Elite OculoPlastic Surgery, PC
Michelle H. White, MD

By signing below, I authorize Michelle H. White, MD 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 Michelle H. White is a participating provider with my insurance plan.** I authorize Elite OculoPlastic Surgery, PC 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 Elite OculoPlastic Surgery, PC and myself.

Authorization: I hereby authorize Elite OculoPlastic Surgery, PC to release any medical or other necessary information insurance carriers require in either paper or digital from concerning my personal health information. I hereby irrevocably assign all payments for all services rendered to Elite OculoPlastic Surgery, PC I also request payment of government benefits either to myself or to Elite OculoPlastic Surgery, PC.

Signature: _____Date: _____

Printed Name: _____

FOR OFFICE USE ONLY

☐ HIPAA CONSENT/AUTH ☐_____☐_____☐_____