Ophthalmic *Plastic Surgery, Inc.*

Ronald T. Martin, M.D., FACS
John D. Langford, M.D., FACS
Richard A. Burgett, M.D., FACS
Michael G. Welsh, M.D., FACS
Scott R. Hobson, M.D., FACS

OPS PATIENT INFORMATION

Thank you for the opportunity to participate in your medical care. We look forward to meeting you and appreciate the opportunity to be of assistance. We hope that this information will answer frequently asked questions regarding your upcoming visit to our office. Additional information is available on our website at www.opsindy.com. If after reading this you have further questions please do not hesitate to call the office. Anyone on our staff would be happy to assist you in any way that we can.

ABOUT OUR SPECIALTY

Our surgeons are among the few surgeons in Indiana who are members of the American Society of Ophthalmic Plastic and Reconstructive Surgery (ASOPRS). Membership in this specialized and exclusive organization is restricted to ophthalmologists who have been board certified by the American Board of Ophthalmology and who have received extensive training in the field of oculofacial plastic and reconstructive surgery.

Our specialty deals with all problems related to the eyelids, tear ducts, and orbit (area behind the eye). This includes aesthetic (cosmetic) surgery, incorporating procedures for the brows/forehead, and mid-face, and eyelids.

Common problems referred to our office include eyelid surgery, tear duct obstruction surgery, cosmetic surgery, reconstruction of the orbit and mid-face following injuries, tumors involving the eyelids or eye socket, care of artificial eye sockets and other problems related to the eye, tear duct, orbit and face.

FEES, BILLING AND INSURANCE

We participate in most health plans. Medicare, Aetna, Anthem, Cigna, Sagamore, United Healthcare are only a few of the many plans with which we participate. If you have any questions about your insurance or our billing policies please do not hesitate to contact us for further assistance.

APPOINTMENTS

YOUR FIRST VISIT IS FOR CONSULTATION ONLY. Any surgeries will be scheduled for a later date.

Our office hours are Monday through Friday 8:00 AM to 5:00 PM (Eastern Standard Time). An after- hours answering service is available all other times. For your convenience, we may also be reached via email to the attention of our office manager at padkins@midwesteye.com

The following paperwork should be completed prior to your appointment and brought to the office with you along with a current government issued photo ID and any insurance cards.

10300 North Illinois St., Suite 2020
Indianapolis, IN 46290
phone (317) 817.1976 or (800) 237.6028
fax (317) 817.1737

Ophthalmic *Plastic Surgery, Inc.*

Ronald T. Martin, M.D., FACS
John D. Langford, M.D., FACS
Richard A. Burgett, M.D., FACS
Michael G. Welsh, M.D., FACS
Scott R. Hobson, M.D., FACS

HIPAA PRIVACY COMPLIANCE

NOTICE OF PRIVACY PRACTICES

As our Patient, a copy of Ophthalmic Plastic Surgery and Interface Aesthetic Surgery's Notice of Privacy Practices is available to you for your information/reference. This is available on our website at www.opsindy.com, from our reception desk, or directly from our practice office and can be shared with you at any time upon request.

COMPLAINTS/COMMENTS

If you have any complaints concerning our privacy practices you may also contact the Secretary of the Department of Health and Human Services at 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201 (e-mail: ocrmail@hhs.gov). YOU WILL NOT BE RETALIATED AGAINST OR PENALIZED BY US FOR FILING A COMPLAINT. To obtain more information concerning this notice you may contact our Privacy Officer:

Pamela Adkins, MHA, Office Manager
Ophthalmic Plastic Surgery/Interface Aesthetic Surgery
10300 N. Illinois St., Suite 2020
Indianapolis, IN 46290

SIGNATURE REQUIRED

Your signature is required below to indicate that the entirety of the Ophthalmic Plastic Surgery and Interface Aesthetic Surgery Privacy Practices policy has been made available to you. A copy of this signature page will be provided to you as well as maintained in your medical chart.

PATIENT SIGNATURE _____ TODAY'S DATE _____

PATIENT NAME (PRINTED) _____

AUTHORIZATION FOR RELEASE OR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT NAME _____ DATE OF BIRTH _____

Name of Person(s) and/or Organization(s) who are being authorized to receive information:

_____

_____

_____

_____

I hereby authorize the release or use and disclosure of my individually identifiable health information (PHI) as described above, I understand that this authorization is voluntary. I also understand that if the person or organization authorized to receive the information is not a health plan, health care provider, or contracted business associate of this practice the released information may no longer be protected by federal privacy regulations. (NOTE: If a patient is unable to sign for themselves, is underage, or if there is Medical Power of Attorney in effect, a legal guardian or the POA must sign this release below as patient representative.)

PATIENT SIGNATURE, LEGAL GUARDIAN OR PATIENT REPRESENTATIVE _____ TODAY'S DATE _____

PRINTED NAME OF GUARDIAN OR REPRESENTATIVE _____

AS APPROPRIATE, DESCRIBE GUARDIAN'S OR REPRESENTATIVE'S RELATIONSHIP TO THE PATIENT _____

WITNESS (WITNESS IS REQUIRED IF SOMEONE OTHER THAN THE PATIENT IS SIGNING ON BEHALF OF THE PATIENT.) _____ TODAY'S DATE _____

REVISED 7/14/2017 PJA

OPHTHALMIC PLASTIC SURGERY

Patient History Form

TODAY'S DATE_____

Patient Name:_____ Date of Birth:_____

Medication Allergies & Reactions:_____

History of Latex Allergy? ____ Yes ____ No Do you or any of your family members have a reaction with anesthesia? Yes_____No_____
If yes, adverse reaction? _____

Referring Doctor_____ Cardiologist (if applicable)_____

Family Doctor_____ Neurologist (if applicable)_____

REVIEW OF SYSTEMS - Do you have or are you being treated for any of the following problems?

System	Yes	No	Condition/Current Treatment PLEASE SPECIFY
Eye disease (eye injury, eye surgery)			
Constitutional (fever, weight loss, other)			
Ears (reduced hearing or hearing loss)			
Nose/Mouth/Throat (sinus problems, sore throat)			
Cardiovascular (heart, vascular, hypertension, heart attack)			Hypertension – Controlled / Unstable
Pacemaker/Defibrillator, heart murmur, abnormal heart rhythm			
Respiratory (breathing problems, cough, asthma, sleep apnea, hay fever)			
Gastrointestinal (diarrhea, vomiting, acid reflux, ulcer, Crohn's disease, ulcerative colitis, hepatitis)			
Neurological (weakness, stroke or mini-stroke, headaches, paralysis, seizures, Parkinson's disease)			Date of last seizure -
Genitourinary (male/or female organ problems, urinary problems, kidney stones)			
Females - Pregnant? / Nursing?			
Dermatologic (skin rashes, skin cancer)			
Musculoskeletal (arthritis, rheumatoid disease, gout, osteoporosis)			
Diabetes			Stable / Unstable / Brittle / Juvenile / Controlled w/diet
Thyroid			
Immunologic (lupus, Sjogren's Syndrome, scleroderma, any immune deficiency)			
Psychiatric (depression, bipolar, schizophrenia)			
Hematologic (bleeding tendency, anemia, leukemia, lymphoma)			
Cancer (type)			

Family History **Relationship** **Social History**

Yes No High blood pressure _____ **Marital Status Married Single Divorced Domestic Partner Widowed**

Yes No Diabetes _____ **Use of Tobacco Yes No Former Quit Date**_____

Yes No Cancer _____ **Use of Illegal drugs Yes No Use of Alcohol Yes No**

Yes No Heart Disease _____ **Currently Employed: Occupation**_____

Patient Name_____ ACCT_____

Current medications including Vitamins, supplements, herbals, anti-inflammatories and aspirin.

PLEASE FILL OUT COMPLETELY, INCLUDING DOSAGE Attached list _____

Name of Medication	Taken for what condition	Dosage	Frequency

History of any surgeries

Procedure	Reason	When:

Preferred Language_____Race_____ Hispanic / Non-Hispanic Decline_____

Patients Signature _____ Date_____

Physicians Signature _____Date_____