REGISTRATION FORM

TODAY'S DATE_____

PLEASE PRINT

Name: _____
(First) **(Middle Initial)** **(Last)**

Address: _____
(Street) **(City)** **(State)** **(Zip Code)**

Home Phone: (____) _____ **Cell:** (____) _____ **Email Address:** _____

□ **Single** □ **Married** □ **Widowed** □ **Divorced** **Sex:** □ **Male** □ **Female**

DOB: _____ **Age:** _____ **SSN:** _____

Occupation: _____ **Office Phone:** (____) _____

Employer: _____ **Address:** _____

Name of Spouse/Parent or Guardian: _____ **DOB:** _____

Address: _____ **Residence Phone:** (____) _____

Employer: _____ **Business Phone:** (____) _____

How did you hear about us? □ **Doctor Referral** □ **Google**
□ **Patient** □ **Social Media**
□ **Magazine** □ **Commercial**
□ **TOC Med Spa** □ **Health Fair**
□ **Website** □ **Other:** _____

Appointment confirmation preference: □ **Text Message** □ **Email** □ **Do not confirm**

Ethnic Background: □ **Hispanic** □ **Not Hispanic**

Race: □ **Indian/Eskimo/Aleut** □ **Asian/Pacific** □ **Islander** □ **Black** □ **Caucasian** □ **Other:** _____

Primary Medical Insurance: _____
(Name) **(Policy Number)** **(Group Number)**

Policy Holder's Name: _____ **SSN:** _____ **DOB:** _____

Secondary Medical Insurance: _____
(Name) **(Policy Number)** **(Group Number)**

Policy Holder's Name: _____ **SSN:** _____ **DOB:** _____

In Case of Emergency, Please Notify: _____
(Name) **(Relationship)**

Work Phone: (____)_____ **Home Phone:** (____)_____

I understand that my physician may release any medical record information of mine or my dependent to evaluate, treat and submit claims to my insurance company. I understand and agree that payment of medical benefits due to me be paid directly to Texas Oculoplastic Consultants. I understand that I am responsible for payment of all services rendered on my behalf or my dependent not covered by my insurance. I agree that payment is due at the time of service unless other arrangements have been made and agreed upon. If payment is not received by agreed dates, I will reimburse TOC Eye and Face the fees of any collection agency, which may be based on a percentage at a maximum of 30% of the debt, and all costs, and expenses, including reasonable attorneys' fees, we incur in such collection efforts. If required, I also understand that a check of my credit history may be made. This consent will remain in effect until revoked by me in writing.

PAYMENT IS EXPECTED AT THE TIME THAT OFFICE SERVICES ARE RENDERED. THANK YOU.

Signature: _____ **Date** _____

I acknowledge that the Notice of Privacy Practices has been made available to me in the lobby of Texas Oculoplastic Consultants.

Signature: _____ **Date** _____

(Revised 06/2020)

TOC MEDICAL HISTORY FORM

Name _____ DOB_____Age_____Height_____Weight_____Date_____

Reason for Visit: _____

MEDICAL ALLERGIES OR SENSITIVITIES

- Do you have any medication or food allergies/sensitivities?
  ☐ No ☐ Yes If so, please list: _____
- Have you ever had any reaction to latex/rubber? ☐ No ☐ Yes Adhesive ☐ No ☐ Yes

If yes to either, please explain: _____

Can you stand and bear your own weight? ☐ Yes
☐ No Please indicate: ☐ Inability to stand ☐ Walker ☐ Wheelchair

MEDICATION ☐ None

Do you take a daily aspirin? ☐ No ☐ Yes Is it preventative ☐ No ☐ Yes

Please list all over the counter and prescribed medications you take:

1._____ 6._____ 11._____
2._____ 7._____ 12._____
3._____ 8._____ 13._____
4._____ 9._____ 14._____
5._____ 10._____ 15._____

OCULAR HISTORY: please check box if you currently have or have ever had these conditions

☐ Anophthalmia (lost an eye)	☐ Right	☐ Left
☐ Amblyopia (lazy eye)	☐ Right	☐ Left
☐ ARMD (macular degeneration)	☐ Right	☐ Left
☐ Cataracts	☐ Right	☐ Left
☐ Glaucoma	☐ Right	☐ Left
☐ Graves' thyroid eye disease	☐ Right	☐ Left
☐ Retinal detachment	☐ Right	☐ Left
☐ Strabismus (crossed eyes)	☐ Right	☐ Left
☐ None		

STAFF USE ONLY:

BP: _____
Pulse: _____
BMI: _____

MEDICAL HISTORY: please check box if you currently have or have ever had these conditions

☐ Arthritis
☐ Asthma
☐ Thyroid disease
☐ Cancer Type: _____
Treatment: ☐ Chemo ☐ Radiation ☐ Surgery
☐ Angina (chest pain)
☐ Irregular heart rhythm or rapid heartbeat (atrial fib, SVT)
☐ High blood pressure (hypertension)
☐ Heart disease (coronary artery disease or heart attack)
☐ Congestive heart failure
☐ HIV
☐ Bleeding disorders
☐ Liver disease (hepatitis) Type _____
☐ Stomach ulcers
☐ Gastroesophageal reflux disease (GERD)
☐ Diabetes
☐ Kidney disease
☐ Tuberculosis
☐ Lung disease (emphysema / COPD)
☐ Requires continuous oxygen
☐ Obstructive sleep apnea ☐ Requires CPAP
☐ Stroke or other Brain injury Date _____
☐ Seizures
☐ Anesthesia Complications
☐ Other _____
☐ None
☐ **FEMALES**: date of last menstrual period? _____

FAMILY HISTORY:

- ☐ Anesthesia complications
- ☐ Bleeding disorders
- ☐ Diabetes
- ☐ Heart disease
- ☐ High blood pressure (hypertension)
- ☐ Thyroid disease

SURGICAL HISTORY: please included ALL previous surgeries, even if not listed

- ☐ Cataract surgery ☐ Right ☐ Left
- ☐ Glaucoma surgery ☐ Right ☐ Left
- ☐ Cardiac pacemaker/defibrillator
  When was your last check? _____
- ☐ Cardiac stent placement When?_____
- ☐ Coronary artery bypass (CABG) When?_____
- ☐ LASIK refractive surgery
- ☐ Eyelid surgery
- ☐ Face lift
- ☐ Nose surgery (rhinoplasty)
- ☐ Other _____
- ☐ None

SOCIAL HISTORY

- Do you smoke? ☐ No ☐ Yes Packs per day _____ How many years? _____ ☐ Formerly When did you quit? _____
- Alcohol use? ☐ No ☐ Yes Frequency ☐ Daily ☐ Weekly ☐ Rarely
- Recreational drug use? ☐ No ☐ Yes Type _____ ☐ Formerly When did you quit? _____

CURRENT PHYSICIANS

Primary Care Physician
Name: _____ Address: _____

Telephone: (____) _____ City/State: _____

Cardiologist (please indicate if not applicable)
Name: _____ Address: _____

Telephone: (____) _____ City/State: _____

Physician Who Referred You (if not your Primary Care Physician)
Name: _____ Address: _____

Telephone: (____) _____ City/State: _____

Preferred Pharmacy (location you would like us to send any medications prescribed)

Name: _____ Address: _____

Telephone: (____) _____ City/State: _____

X _____ _____

Patient Signature ***Date***

HIPAA Release of Information
AUTHORIZATION FORM

This optional Authorization grants permission to the Designated party (ex: spouse, parent, etc.) named below to:

- **Make or confirm appointments**
- **Have access to x-ray, laboratory, or test findings**
- **Have access to telephone communication and answering machine messages as well as other common means of communication, including but not limited to text messages containing personal health information.**
- **Pick up sample medications**
- **Be made aware of my diagnosis, prognosis, and treatment plans**
- **Have access to my financial health information and medical records.**

I hereby authorize TOC Eye and Face to use and disclose my individually identifiable health information as described above. I understand that this authorization is voluntary. I understand that once this information is released to the Designated Party(ies) named below, the released information may no longer be protected by federal privacy regulations.

Patient Name:_____ **Date of Birth:_____**

Mobile Phone: _____

Designated party:_____ Relationship to patient:_____

Address_____

Phone:_____ Email: _____

Designated party:_____ Relationship to patient:_____

Address:_____

Phone:_____ Email: _____

The patient or patient's representative must read and initial the following statements:

1. I understand that this authorization will: ***(Must check one)***
   ( ) expire 1 year from the date signed by the patient or patient's representative; or
   ( ) be effective for the lifetime of the patient unless revoked

2. I understand that I may revoke this authorization at any time by notifying in writing; however, if I do revoke the authorization, it will not have any effect on any actions taken by ***Texas Oculoplastic Consultants*** prior to their receipt of the revocation.

3. I understand that my treatment cannot be conditioned on whether I sign this authorization.

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

_____ _____
Signature of patient or patient's representative Date
(*Form **MUST** be completed before signing or will not be valid)*

Printed Name of Patient's Representative: _____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

TOC
EYE AND FACE

CONSENT TO PHOTOGRAPHY

I hereby authorize photographs to be taken for medical purposes.
I agree to the use of the negative, prints, copies or reproductions for insurance documentation, teaching and for monitoring my condition.

_____ _____
Signature of patient Date

_____
Printed Name

I am open to TOC Eye and Face using my before and after photographs for marketing. If checked, a TOC staff member will contact you for formal written permission before posting or publishing.

☐ Yes ☐ No

If the patient is a minor or unable to sign, complete the following:

Father_____

Mother_____

Guardian or other person/relationship_____

Texas Oculoplastic Consultants

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. PLEASE REVIEW IT CAREFULLY.

Our goal is to take appropriate steps to attempt to safeguard any medical or other personal information that is provided to us. The Privacy Rule under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires us to (i) maintain the privacy of medical information provided to us, (ii) provide notice of our legal duties and privacy practices and (iii) abide by the terms of our Notice of Privacy Practices currently in effect.

WHO WILL FOLLOW THIS NOTICE

- This notice describes the practices of our employees and staff. This notice applies to all TOC individuals, entities, sites and locations. In addition, these individuals, entities, sites and locations may share medical information with each other for treatment, payment and health care operation purposes described in this notice.

INFORMATION COLLECTED ABOUT YOU

In the ordinary course of receiving treatment and health care services from us, you will be providing us with personal information such as:

- Your name, address and phone number.
- Information relating to your medical history.
- Your insurance information and coverage.
- Information concerning your doctor, nurse or other medical providers.

In addition, we will gather certain medical information about you and will create a record of the care provided to you. Some information also may be provided to us by other individuals or organizations that are part of your "circle of care" – such as the referring physician, your other doctors, your health plan and close friends or family members.

HOW WE MAY USE AND DISCLOSE INFORMATION ABOUT YOU

We may use and disclose personal and identifiable health information about you for a variety of purposes. All of the types of uses and disclosures of information are described below, but not every use or disclosure in a category is listed.

Required Disclosures. We are required to disclose health information about you to the Secretary of Health and Human Services, upon request, to determine our compliance with HIPAA and to you, in accordance with your right to access and right to receive an accounting of disclosures, as described below.

For Treatment. We may use health information about you in your treatment. For example, we may use your medical history, such as any presence or absence of diabetes, to assess the health of your eyes.

For Payment. We may use and disclose health information about you to bill for our services and to collect payment from you or your insurance company. For example, we may need to give a payer information about your current medical condition so that it will pay us for the eye examinations or other services that we have furnished you. We may also need to inform your payer of the treatment you are going to receive in order to obtain prior approval or determine whether the service is covered.

Disclosures to Persons Assisting in Your Care or Payment for Your Care. We may disclose information to individuals involved in your care or in the payment for your care. This includes people and organizations that are part of your "circle of care" – such as your spouse, your other doctors or an aide who may be providing services to you. We may also use the disclosure health information about a patient for disaster relief efforts and to notify persons responsible for a patient's care about a patient's location, general condition or death. Generally, we will obtain your verbal agreement before using or disclosing health information in this way; however under certain circumstances such as in an emergency situation, we may make these uses and disclosures without your agreement.

PERSUANT TO: 84TH TEXAS LEGISLATIVE REGULAR SESSION, HB 764 SECTION 108.0095. NOTIFICATION OF DATA COLLECTION which states: A provider shall provide to a patient whose data is being collected under this chapter written notice on a form prescribed by the department of the collection of the patient's data for health care purposes. The notice provided under this section must include the name of the agency or entity receiving the data and of an individual within the agency or entity whom the patient may contact regarding the collection of data. The department shall include the notice required under this section on an existing department form and make the form available on the department's internet website.

This document shall provide notice to patients that the Texas Department of State Health Services, Texas Healthcare Information Collection program (THCIC) receives patient claim data regarding services performed by the named Provider. The patients claim data is used to help improve the health of Texas, through various methods of research and analysis. Patient confidentiality is upheld to the highest standard and is not subject to public release. THCIC follows strict internal and external guidelines as outlined in Chapter 108 of the Texas Health and Safety Code and the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

For further information regarding the data being collected, please send all inquiries to: Chris Aker
THCIC
Dept. of State Health Services
Center for Health Statistics, MC 1898 PO
Box 149347
Austin, Texas 78714-9347

Location
Moreton Building, M-660 1100
West 49th Street Austin, TX
78756
Phone: 512-776-7261
Fax: 512-776-7740
Email: thcichelp@dshs.state.tx.us

Request for Amendment of Protected Health Information

You have the right to request an amendment of your protected health information maintained by Texas Oculoplastic Consultants if you believe the information is not accurate or completed. You must submit your request through our patient portal. If the patient is a minor child, the legally authorized representative must request the amendment through the patient portal.

If your request for amendment is approved, the original documentation will not be changed or deleted. Your amendment will be appended or l inked to the information that is being amended.