Atlanta Oculofacial Plastic Surgeons
Brent A. Murphy, M.D.

Patient Information

Last Name:_____ First Name:_____ MI:_____

❑Male ❑ Female DOB: _____ /_____ /_____ SSN:_____

Address:_____

City:_____ State: _____ Zip Code:_____

Contact Information and Consent

Primary Contact Number: _____ Please Circle One: Home Cell Work

Backup Contact Number: _____ Please Circle One: Home Cell Work

Primary Email:_____ Please Circle One: Personal Work

May we leave a message on your Primary Contact voicemail? Yes or No

May we text message you? Yes or No

May we send you an email? Yes or No
Please note: email is not a secure method of communication. Health Information sent via email may not be private.)

May we leave a message with another Person? Yes or No

Referral Source/PCP

Primary Care Physician Name:_____ Phone: _____

Referring Physician Name: _____Phone:_____

❑ Word of Mouth ❑ Previous Patient ❑ Other _____

Demographics

Race: ❑ African American ❑ American Indian or Alaska Native ❑ Asian ❑ Native Hawaiian or Other Pacific Islander ❑ White ❑ Decline to state

Marital Status: ❑ Single ❑Married ❑Other **Ethnicity:** ❑ Decline to state ❑ Hispanic or Latino ❑ Not Hispanic or Latino

Language: _____

Smoking Status: ❑ Current every day smoker ❑ Current Some day smoker ❑ Former Smoker ❑ Never Smoker ❑ Unknown

Emergency Contact Information

Name: _____ **Phone:** _____ **Relationship:** _____

Employment Status

❑ Employed ❑ Retired ❑ Homemaker ❑ Full-time Student ❑ Part-time Student ❑ Unemployed

Employer: _____

Insurance Information

Primary Insurance:_____ ID #:_____ Group #:_____

Policy Holder Name:_____Relationship:_____ Policy Holder DOB:_____

Policy Holder Address:_____

City:_____ State: _____ Zip Code:_____

Secondary Insurance:_____ ID #:_____ Group #:_____

Policy Holder Name:_____Relationship:_____ Policy Holder DOB:_____

Policy Holder Address:_____

City:_____ State: _____ Zip Code:_____

Consent for Evaluation and/or Treatment:

By signing, I am giving my consent to Atlanta Oculofacial Plastic Surgeons, Dr. Brent A. Murphy, for evaluation and/or treatment. Once I have been examined, I understand that I will be informed of any recommendations for treatment in the office and/or surgery, diagnostic procedures or treatments and given the option to accept or decline.

Patient Name:_____ **Date:**_____

Signature:_____ **Relationship to Patient:**_____

Managed Care/HMO Patients

I understand that it is my responsibility to obtain a valid referral from my primary care physician. I understand that if I do not obtain or have a referral on file that I may be held financially responsible for services received. I further understand that I am responsible for services that are considered non-covered expenses by my insurer.

Patient Signature:_____ Date:_____

Parent/Guardian Signature (if minor):_____ Date:_____

(July 2018)

Assignment of Benefits

I request that payment of authorized medical benefits is made on my behalf directly to Atlanta Oculofacial Plastic Surgeons for service(s) furnished to me. I authorize Atlanta Oculofacial Plastic Surgeons to release any medical information to my health insurance carrier and/or its legitimate agents that is necessary to process related health insurance claims and/or to verify plan benefits in accordance with HIPAA health information standards. I authorize payment of service(s); otherwise payable to me under the terms of my private, group employer's/group health insurance plan, or Medicare directly to Atlanta Oculofacial Plastic Surgeons. I hereby authorize that a copy of this form to be valid as the original.

Patient Name:_____ **Date:**_____

Signature:_____ **Relationship to Patient:**_____

HIPAA/Privacy

Please tell us with whom we can discuss your protected health information/appointment details with:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient Name: _____ **Date:** _____

Signature: _____ **Relationship to Patient:** _____

(July 2018)

Atlanta Oculofacial Plastic Surgeons

FINANCIAL POLICIES

Thank you for taking the time to meet with Dr. Murphy for your consultation. Below is our office financial policy for both cosmetic and insurance patients. Please let us know if you have any questions.

For Our Insurance Patients

It is our policy that payment is due at the time of service unless other financial arrangements are made in advance. We require all patients to pay their deductible, copay and/or coinsurance payment at the beginning of each visit. Upon check-out additional fees may be due. If we are **Out of Network** with your insurance company/plan, you will be responsible for full payment at the time of service. We will prepare and send the claim in for you on an unassigned basis.

Medicare Patients: As Participating Providers, we agree to accept an amount of payment equal to the Medicare "allowable" for covered services. Medicare pays 80% of the allowable. You or your secondary/supplemental insurance will be responsible for paying the remaining 20% of the allowable and any deductibles.

We will verify your benefits with your insurance company. This is not a guarantee of benefits or payment. Your claim will process according to your plan. Claims will be paid based on eligibility and benefits at the time of service. Actual fees, allowable, and patient responsibility are determined once the claim is submitted and the Explanation of Benefits received from your insurance company.

Although we are contracted with many insurance carriers, our services may not be covered by your particular insurance plan. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full.

Being referred to our office by another physician does not necessarily guarantee that your insurance will cover our services. Please remember that you are responsible for all charges incurred. Your physician's referral and our verification of your insurance benefits are not a guarantee of payment.
We recommend you contact your insurance company and check into your coverage prior to your appointment. Please do not assume that you will not owe anything if you have more than one insurance policy.

If your insurance company does not pay within a reasonable period of time, you will be billed. If we later receive payment for your insurer, we will refund any overpayment to you.

In the event surgery is needed, we will obtain precertification/authorization/predetermination prior to your surgery. The authorization process does take time; we will schedule your surgery approximately four (4) weeks out to allow time for authorization. You will be provided with an Estimate of Fees for Dr. Murphy only. Once surgery is authorized, you will be contacted by phone, about two (2) weeks prior to surgery, to pay the Estimated Patient Responsibility in full. We accept: Visa, MasterCard, Discover, American Express, money orders, cashier's checks and cash. Personal checks are only accepted if paid two (2) weeks prior to surgery. No post-dated checks will be accepted. There is a $30.00 charge associated with any returned check.

For Our Cosmetic Patients

It is our policy that payment is due at the time of service. We accept: Visa, MasterCard, Discover, American Express, money orders, personal checks (for in-office only), cashier's checks and cash. For Surgery: Personal checks are only accepted if paid two (2) weeks prior. No post-dated checks will be accepted. There is a $30.00 charge associated with any returned check.

It is our policy that a booking fee of $500 is payable upon scheduling of your surgery in order to secure a date on the physician's schedule. Because the scheduling of your surgery requires a significant time commitment on the part of your physician, his staff and the facility; this booking fee is non-refundable. It is however, transferable if you should need to reschedule your surgery date.

At the time of your pre-operative appointment the remainder of the "total package price" will be expected to be paid in full.

Cosmetic procedures are not covered by your insurance. You will be responsible for all fees associated with surgery (anesthesia, facility, supplies, and pathology (if applicable). Cosmetic surgery quotes expire after 180 days.

You will receive a Quote for your cosmetic procedures, a more detailed financial policy and information will be discussed at that time. The above is not the complete policy for Cosmetic Surgical Procedures.

Patient Financial Agreement

I understand and agree that regardless of my insurance company's determination, I am ultimately responsible for the balance on my account for services rendered. I have read the above Financial Policies. I will notify the practice of any changes in my health insurance coverage immediately. I hereby authorize that a copy of this form to be valid as the original.

Patient Name:_____ **Date:**_____

Signature:_____ **Relationship to Patient:**_____

Atlanta Oculofacial Plastic Surgeons

Date: _____

Name: _____ Date of Birth: _____/_____/_____ Age: _____

Referring Provider: _____ Phone: _____ Fax: _____

PCP: _____ Phone: _____ Fax: _____

Pharmacy: _____ Phone: _____ Fax: _____

Height: _____ Weight: _____

Reason for your visit today?_____

Current Medications: Include prescription, over the counter, vitamins and supplements

Drug	Dosage

Current Ocular Medications:

Drug	Dosage

Patient Medical History:

	YES	DETAILS
Abnormal Cholesterol	❑	
Acid Reflux	❑	
Atrial Fibrillation (Afib)	❑	
Anemia	❑	
Anesthesia Problems	❑	
Asthma	❑	
Auto Immune Disease	❑	
Bleeding Problems	❑	
Blood Clots/DVT	❑	
Breast Cancer	❑	
Bronchitis	❑	
Cancer (If yes, please specify the type)	❑	
Cardiac Cath	❑	
Cardiac Stent Placement	❑	
Cervical (Neck) Arthritis	❑	
Chronic Hepatitis B	❑	
Cirrhosis	❑	

MEDICAL HISTORY CONTINUED:	YES	DETAILS
Dementia	❑	
Diabetes (Diet Controlled)	❑	
Diabetes (Taking Insulin)	❑	
Diabetes (Taking Oral Medications)	❑	
Diet Pills	❑	
Do you have dentures, partials, caps, bonding, loose or chipped teeth?	❑	
Eczema	❑	
Emphysema COPD	❑	
Epilepsy	❑	
Glaucoma	❑	
Have you had your **Influenza (Flu) Vaccination?**	❑	When?
Have you ever received a **Pneumonia Vaccination**?	❑	When?
Heart Disease/Heart Problems	❑	
Heart Valve Replacement	❑	
Hepatitis C	❑	
Hiatal Hernia	❑	
High Blood Pressure	❑	
High Blood Sugar	❑	
HIV	❑	
Hives	❑	
Juandice	❑	
Kidney Disease	❑	
Kidney Stones	❑	
Limitations/Devices: Do You wear glasses, contact lenses, hearing aids, mobility cognitive	❑	
Malignant Hyperthermia – Personal or Family History	❑	
Migraines	❑	
MS	❑	
Muscle Weakness	❑	
Myasthenia Gravis	❑	
Obesity/Overweight	❑	
Organ Transplant	❑	
Osteoporosis	❑	
Other (Please Explain)	❑	
Pacemaker/Defibrillator	❑	
Rheumatoid Arthritis	❑	
Seizure	❑	
Sickle Cell Anemia	❑	
Sleep Apnea	❑	
Sleep Apnea w/CPAP	❑	
Spinal Cord Injury	❑	
Stroke/TIA	❑	
Thyroid Disorder	❑	
Tuberculosis	❑	
Under care of a psychiatrist?	❑	
None	❑	

Surgical History

Surgery/Hospitalization	Date:	Anesthesia Problems:	Notes:
❑ I have had no Surgery/Hospitalizations			

Allergies to Medications

Medication	Onset	Reaction	Severity
❑ NO KNOWN DRUG ALLERGIES			**Please Note either: Mild, Mild to Moderate, Moderate to Severe, or Severe**
❑ LATEX ALLERGY			

Family History

	Yes	Afflicted Family Member	Notes
No Contributing Family History	❑		
Adopted and is not aware of family history	❑		
Abnormal Bleeding	❑		
Abnormal Clotting	❑		
Anesthesia Problems	❑		
Autoimmune Disorders	❑		
Breast Cancer	❑		
Other Cancers	❑		
Diabetes	❑		
Endocrine Disease	❑		
Heart Disease	❑		
High Blood Pressure	❑		
Hemophilia	❑		
Kidney Disease	❑		
Liver Disease	❑		
Lung Disease	❑		
Malignant Hyperthermia	❑		

Social History

Smoking	Alcohol	Marital Status
❑ Non Smoker ❑ Current Smoker ❑Previous Smoker When Did you Quit _____	❑ Never Drink Alcohol ❑ Occasionally/Social ❑ 1-2 Drinks/Day ❑ 3-4 Drinks/Day	❑ Married ❑ Single ❑ Divorced ❑ Widowed ❑ Separated ❑ Partner ❑ Unknown
Substance Abuse	**Occupation**	**Driving**
❑ None ❑Marijuana ❑ Other: _____	❑ Retired ❑Unemployed ❑ Disabled ❑ Not Working ❑Working Occupation:_____ _	Do you Drive? ❑ Yes ❑ No
Living Conditions		
❑ Alone ❑ Nursing Home ❑ Retirement Center ❑ With Caretaker ❑ With Family ❑ Unknown		

Atlanta Oculofacial Plastic Surgeons

Photograph Consent and Release

I hereby acknowledge that I have been advised that photographs will be taken of me or parts of my body before and after surgery. The photographs will be taken by one of the members of the Atlanta Oculofacial Plastic Surgeons, P.C. medical staff. I hereby give my consent for Atlanta Oculofacial Plastic Surgeons, P.C. to use the photographs under one of the following circumstances.

Please initial one (or more) of the following:

_____ **Internet:** Photographs taken of me or parts of my body as well as details regarding medical services that I have received at Atlanta Oculofacial Plastic Surgeons, P.C., can be used on the company's website in order to inform the public about plastic surgery methods. Further, I release and discharge Atlanta Oculofacial Plastic Surgeons, P.C., any employees of Atlanta Oculofacial Plastic Surgeons, P.C., and the American Society of Plastic Surgeons; and all parties acting under their license and authority, from any and all claims or actions that I have or may have relating to such use and publication, and all rights, if any, that I may have in such photographs and details regarding medical services rendered me, including any claim for payment, in connection with any such use or publication. I give my consent as a voluntary contribution in the interest of public education, and my consent is subject only to the condition that I am not identified by name or any other identifying marks at any time during any use or publication of these materials by any party.

_____ **All Media:** Photographs taken of me or parts of my body as well as details regarding medical services that I have received at Atlanta Oculofacial Plastic Surgeons, P.C., can be used in any print or broadcast media, including, but not necessarily limited to newspapers, pamphlets, educational films, internet, and television, in order to inform the public about plastic surgery methods. Further, I release and discharge Atlanta Oculofacial Plastic Surgeons, P.C., any employees of Atlanta Oculofacial Plastic Surgeons, P.C., and the American Society of Plastic Surgeons; and all parties acting under their license and authority, from any and all claims or actions that I have or may have relating to such use and publication, and all rights, if any, that I may have in such photographs and details regarding medical services rendered me, including any claim for payment, in connection with any such use or publication. I give my consent as a voluntary contribution in the interest of public education, and my consent is subject only to the condition that I am not identified by name at any time during any use or publication of these materials by any party.

_____ **Medical Care Only:** Photographs taken of me or parts of my body can be used solely for the purpose of my medical care with Atlanta Oculofacial Plastic Surgeons, P.C. The photographs and all details regarding medical services rendered to me will be kept confidential within my personal medical history file at Atlanta Oculofacial Plastic Surgeons, P.C.

By signing this form, I acknowledge my consent as initialed above, and I further recognize that this consent form will supersede any other photo consent forms with a date prior to the date written below. This consent may be revoked at any time by written request or by completion of a new form.

_____

Signature (Patient or Parent/Guardian if Patient is under 18) Date

Atlanta Oculofacial Plastic Surgeons

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

We are legally required to give you this Notice and to get a signed statement that you received it. By signing this form, you are saying that you have received Atlanta Oculofacial Plastic Surgeons' Notice of Privacy Practices.

Atlanta Oculofacial Plastic Surgeons Notice of Privacy Practices tells you how we can use and disclose your health information. It also describes certain rights you have about your health information kept by us. Please review the Notice of Privacy Practices carefully.

The undersigned hereby acknowledges receipt of Notice of Privacy Practices for Atlanta Oculofacial Plastic Surgeons and each of its locations.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patients signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date: _____ Initials: _____ Reason: _____

Atlanta Oculofacial Plastic Surgeons

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Effective Date: July, 2018

If you have any questions about this notice or if you need more information, please contact our privacy officer:

Privacy Officer:	Deana Ferraiuolo
Mailing Address:	755 Mount Vernon Hwy, NE
	Suite 210
	Atlanta, GA 30328
Phone:	(404) 480-4008
Fax:	(404) 480-4007

Our Responsibilities

We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing you change your mind. **For more information see:** www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.

- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice
You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you
- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated
- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices
For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:
- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory
  If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:
- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:
- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures
How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Treat you
- We can use your health information and share it with other professionals who are treating you.
  Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization
- We can use and share your health information to run our practice, improve your care, and contact you when necessary.
  Example: We use health information about you to manage your treatment and services.

Bill for your services
- We can use and share your health information to bill and get payment from health plans or other entities.
  Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues
We can share health information about you for certain situations such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services
-

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.