FIFTH AVENUE
ASSOCIATES

1034 Fifth Avenue
New York, NY 10028

Tel: 212•570•0707
Fax: 212•570•0555

EYES.FACES

www.faeye.com

Patient: ☐ Mr. ☐ Ms. ☐ Mrs. ☐ Dr. _____ _____
First Name Last Name

Date of Birth: _____/_____/_____ Age: _____ Gender: ☐ M ☐ F

Marital Status: ☐ Married ☐ Divorced ☐ Widowed ☐ Single ☐ Domestic partner

Preferred Language/ Ethnicity /Race: _____

Permanent Address: _____ Apt.:_____

City: _____ State: _____ Zip: _____

Home Phone: ( ) _____ Cellular: ( ) _____ Email: _____

Preferred method of contact: ☐ Home ☐ Cell ☐ Email

Employer: _____ Occupation: _____

Work Address: _____

City: _____ State: _____ Zip Code: _____

Work Phone: ( ) _____

Emergency Contact: _____ Relationship: _____ Phone: ( ) _____

Primary Insurance Plan: _____ ID #: _____

Policy Holder: ☐ Self ☐ Spouse ☐ Parent

If Not Self: Name: _____ Date of Birth: ___/____/____Social Security Number: _____

Secondary Insurance Plan:_____ ID #: _____

Primary Care Physician: _____ Phone: _____

Address: _____

Pharmacy Name: _____ Phone: _____

Address: _____

How did you hear about us? Please check any that apply:

- ☐ A friend or family member (please name) _____
- ☐ Physician referral (please name)_____
- ☐ Internet (please name site) _____
- ☐ Other (please name)_____

Confidential Patient Questionnaire

REVIEW OF SYSTEMS

Do you currently, or have you ever had problems in the following areas?

	YES	NO
CONSTITUTIONAL		
Fever, weight loss/gain	☐	☐
Other_____	☐	☐
VASCULAR/CARDIOVASCULAR		
Heart problems	☐	☐
Chest pain	☐	☐
Irregular heartbeat	☐	☐
Other_____	☐	☐
GASTROINTESTINAL		
Heartburn	☐	☐
Abdominal pain	☐	☐
Diarrhea	☐	☐
Vomiting	☐	☐
Other_____	☐	☐
NEUROLOGICAL		
Numbness	☐	☐
Weakness	☐	☐
Headaches	☐	☐
Paralysis	☐	☐
Other_____	☐	☐
ALLERGIC/IMMUNOLOGIC		
Hay fever	☐	☐
Allergies	☐	☐
Other_____	☐	☐
PSYCHIATRIC		
Depression	☐	☐
Anxiety	☐	☐
Other_____	☐	☐

	YES	NO
EARS, NOSE, MOUTH, THROAT		
Allergies/ Hay Fever	☐	☐
Other_____	☐	☐
RESPIRATORY		
Asthma	☐	☐
Shortness of breath	☐	☐
Wheezing	☐	☐
Coughing	☐	☐
Other_____	☐	☐
DERMATOLOGIC		
Skin rashes	☐	☐
Excessive dryness	☐	☐
Other_____	☐	☐
MUSCULOSKELETAL		
Muscle aches	☐	☐
Joint pain	☐	☐
Swollen joints	☐	☐
Other_____	☐	☐
HEMATOLOGIC/LYMPHATIC		
Blood disorders	☐	☐
Leukemia	☐	☐
Other_____	☐	☐
ENDOCRINE		
Thyroid problems	☐	☐
Diabetes	☐	☐
Other_____	☐	☐

If you answered YES to any of the above or added a condition not listed, please explain:

_____

_____

Please list all medications you are taking including eye drops:

_____

_____

Do you have allergies to any medications? ☐ YES ☐ NO

If YES, please list: _____

Confidential Patient Questionnaire (continued)

Family and Social History: Do any of the following ocular or medical conditions run in your family? If YES, please specify the type of family relationship:

☐ Glaucoma _____

☐ Diabetes _____

☐ High blood pressure _____

☐ Macular degeneration _____

☐ Other (please explain) _____

Do you smoke? ☐ YES ☐ NO If YES, how many cigarettes/packs per day? _____

Do you consume alcohol? ☐ YES ☐ NO If YES, how often? _____

Ocular:

In order to ensure that we address all of your potential concerns, please identify any of the following you would like to discuss with your physician today:

☐ I would like to decrease my dependency on reading glasses

☐ I would like to be able to see objects in the distance without the use of glasses or contact lenses

☐ I would like to be able to see near and far without the use of glasses or contact lenses

☐ Cataract removal

☐ I would like to be fitted for contact lenses

☐ I would like to see a range of prescription glasses and sunglasses available in the office

☐ Other: _____

Plastics and Aesthetic:

Dr. Ebby Elahi and Dr Susan Zoltan are board certified Oculofacial Plastic Surgeons with extensive experience in functional and aesthetic procedures. Please identify any areas of concern you would like to discuss with your physician today:

☐ Droopy eyelids

☐ Heavy brows

☐ Bulging eyes (Thyroid Eye Disease)

☐ Hollow eyes

☐ Dark circles

☐ Sagging skin of the face/neck

☐ Unwanted moles/lesions

☐ Skincare advice

☐ Fine lines and wrinkles

☐ Deep laugh lines

☐ Vertical lip lines

☐Thin lips

☐ Red/brown spots

☐ Spider/facial veins

☐ Excess hair

☐ Other _____

Patient Financial Responsibility

Refraction:
Refraction is the process of determining the eye's refractive error or the need for corrective glasses and/or contact lenses. Refraction is sometimes necessary depending on the patient's diagnosis and/or complaints presented. For example, if a patient experiences blurred vision or a decrease in visual acuity on the eye chart, refraction would be necessary to determine if this is due to a need for glasses or a medical problem. Refraction is also necessary to prove the need for cataract surgery to insurance carriers. We must prove that your vision cannot simply improve with a glasses prescription. Refraction is often an essential part of an eye exam; however, MEDICARE and some INSURANCE CARRIERS do not cover the charge for refraction.
ONLY the doctor or technician is qualified to tell you if this procedure is necessary and they will inform you of the necessity BEFORE it is done. It is important to understand that if you decline this procedure, we may not be able to determine the cause for your decrease in vision.

The cost of refraction:
Our office policy is to charge **$190** for this procedure in addition to the office visit co-pay and/or deductible. Payment is due at the time services are rendered. NOTE: This fee is due and payable whether or not you receive a written glasses prescription. Sometimes the change in vision is not significant enough to warrant the cost of purchasing new glasses.

Contact lenses:
Contact lenses ARE NOT considered medically necessary. To be fit for contact lenses you will be charged a fee. This will involve the fitting fee of the physician, the training of how to insert and remove the lenses and how to clean them. If disposable contact lenses are prescribed, 1 box of lenses for each eye will be ordered for you. If you need to be refit in a different brand/type, you will be charged a fee for the physician's time, as all contact lenses are different (i.e., base curve and diameter).

Non-covered services:
I understand that 5th Ave Associates/5th Ave Oculofacial Aesthetic Surgery's contracts with health care service plans (i.e., HMOs, PPOs) relate only to items and services that are "covered" by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient; and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with 5th Ave Associates/5th Ave Oculofacial Aesthetic Surgery to obtain necessary health care service plan authorizations. Patients with HMO referral plans are responsible to bring their referral at time of service. If no referral, you may be billed.

Financial agreement:
I agree that in return for the services provided to the patient by 5th Ave Associates/5th Ave Oculofacial Aesthetic Surgery I will pay my account at the time service is rendered or will make financial arrangements satisfactory to 5th Ave Associates/5th Ave Oculofacial Aesthetic Surgery for payment. If an account is sent for collection, I agree to pay any such collection expenses. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to 5th Ave Associates/5th Ave Oculofacial Aesthetic Surgery. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to 5th Ave Associates/5th Ave Oculofacial Aesthetic Surgery. However, it is understood that the undersigned and/or the patient are primarily responsible for the paysment of my bill.

Acknowledgement:
I have read the above information and understand my financial responsibilities as a patient of 5th Ave Associates/5th Ave Oculofacial Aesthetic Surgery.

Date: _____ Patient Name:_____

Patient Signature:_____

Patient Representative: _____
(if applicable)

Assignment of Benefits

Medicare:

I request that payment of authorized Medicare benefits be made on my behalf to 5th Ave Associates/5th Ave Oculofacial Aesthetic Surgery for services furnished me by 5th Ave Associates/5th Ave Oculofacial Aesthetic Surgery. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. 5th Ave Associates/5th Ave Oculofacial Aesthetic Surgery accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

Secondary insurance:

I understand that if a secondary insurance policy is indicated in item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to 5th Ave Associates/5th Ave Oculofacial Aesthetic Surgery, if possible, or otherwise to me.

Release of information:

5th Ave Associates/5th Ave Oculofacial Aesthetic Surgery may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease or HIV, to any person or corporation (1) which is or may be liable or under contract to 5th Ave Associates/5th Ave Oculofacial Aesthetic Surgery for reimbursement services rendered, and (2) any health care provider for continued patient care. 5th Ave Associates/5th Ave Oculofacial Aesthetic Surgery may also disclose on an anonymous basis any information concerning my case which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation.

Other insurance:

I understand that 5th Ave Associates/5th Ave Oculofacial Aesthetic Surgery maintains a list of heath care service plans with which it contracts (a list of such plans is available from the business office), and that 5th Ave Associates/5th Ave Oculofacial Aesthetic Surgery has no contract, expressed or implied, with any plan that does not appear on the list. I agree that I am individually obligated to pay the full charges of all services rendered to me by 5th Ave Associates/5th Ave Oculofacial Aesthetic Surgery if I belong to a plan that does not appear on the above mentioned list.

I grant 5th Ave Associates/5th Ave Oculofacial Aesthetic Surgery permission to take photographs/film of myself or dependent child to be used and distributed for educational, clinical and/or scientific purposes. The use of these photos/films can include presentations, meetings, publications as well as patient education. The photographs may include identifiable features of the face or body.

Resolution of concerns:

I understand that I am entering into a contractual relationship with my Physician for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by my Physician, I the patient/guardian and/or my representative agree not to advance, directly or indirectly, any false, meritless, and/or frivolous claim(s) of medical malpractice against my Physician. Furthermore, should a meritorious medical malpractice case or cause of action be initiated or pursued, I (the patient) and/or my representative agree to use American Board of Medical Specialties (“ABMS”) board certified expert medical witnesses in the same specialty as my Physician. Furthermore, I agree that these expert witness will be members in good standing of and adhere to the guidelines and/or code of conduct defined for expert witnesses by Ophthalmologists.

_____Initials

Patient Consent Form

Use and Disclosure of Health Information Protected under HIPAA

Pursuant to the information contained in the Notice of Privacy Practices, I give permission for the use and disclosure of Protected Health Information (PHI) in order to carry out Treatment, Payment, and Healthcare Operations (TPO).

I am aware that I have the right to review the Notice of Privacy Practices prior to signing this consent. Should the Notice of Privacy Practices be revised, I am aware that I may obtain a copy of the revised form by contacting the Medical Director of this facility.

I give my consent for this organization to contact me by calling my home or other designated location in order to leave a message (mechanically or with another person) or to speak to me directly regarding any matter which will help with the conduct of Treatment, Payment, and Healthcare Operations.

Further, I give my consent for the use of mail or e-mail to designated locations, including my home, to assist the organization in carrying out the described activities of Treatment, Payment, and Healthcare Operations.

I hereby consent to the use and disclosure of my PHI for the purpose of Treatment, Payment, and Healthcare Operations (TPO). This consent is good until revoked in writing, except to the extent that disclosures have been made in reliance upon my prior consent.

Services are provided without regard to sex, race, color, religion, national origin, or disability.

Date: _____

Patient Name: _____

Patient Signature: _____

Patient Representative: _____

(if applicable)

We are compliant with HIPAA (privacy of health information). A copy of this notice is available to you upon request.