PORTLAND
OCULOPLASTICS
SCOT A. SULLIVAN, M.D.
10305 SW Park Way, Suite 203
Portland, OR 97225

Appointment

Day:_____

Date:_____

Time:_____

Patient Name _____

We would like to welcome you to Portland Oculoplastics, P.C. This letter is to confirm your appointment with Dr. Sullivan. Please read and complete the following forms prior to your visit, if unable please arrive 15 Minutes prior.

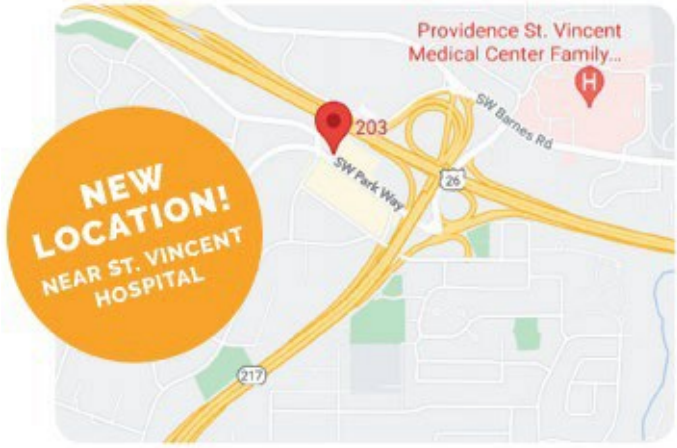
Location & Driving Direction

From US-26 (West)

- Take Park Way/Barnes Rd -Exit #69B
- Continue on Park Way
- Destination on the Right

From US-26 (East)

- Take Park Way/Barnes Rd -Exit #69B
- Left on Baltic Ave
- Right on Park Way
- Destination on the Right



From OR-217 (South)

- Follow signs to US-26 E towards Portland
- Take Wilshire St exit
- Right on Wilshire St (towards DMV)
- Right at stop towards Hwy 26 Tillamook/Astoria
- Left on Park Way
- Destination on the Right

Due to the nature of our clinic, unforeseen circumstances can appear on a day to day basis. Your wait time may vary, however your time spent with Dr. Sullivan will never be condensed.

Sincerely,
Portland Oculoplastics

OFFICE/FINANCIAL POLICY

We require patients to provide a copy of their insurance card, proof of identification and co-payment at check-in for the initial visit. If you do not have your insurance card, photo ID or co-payment with you at the time of your visit, you may be required to pay upfront for the visit. Some insurance plans require a referral from primary care provider, one must be obtained prior to the visit

PATIENT RESPONSIBILITY
Patients are responsible for all charges resulting from treatment provided by Portland Oculoplastics. Payment is due in full within 30 days of receiving your first statement unless other financial arrangements have been made with the Billing Office. Please remember your insurance policy is an agreement between you and your insurance company, and it is ultimately your responsibility to pay for any balance not paid or covered by your insurance company. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request.

CO-PAYMENTS, DEDUCTIBLES AND CO-INSURANCE
Co-payments are the amounts your insurance policy requires us to collect with each visit and are due at the time of service.). The deductible is the total amount your policy requires you to pay before they will pay claims on your behalf. We may ask you to pay the estimated unmet portion of your deductible at the time of service.

INSURANCE BILLING
As a courtesy, we will bill your primary and secondary insurances for you. However, primary responsibility for the account is yours. Providing correct insurance billing information is the responsibility of the patient. If your insurance changes, please call our office or present your new card at your visit. If you do not provide us with valid insurance information, you may need to pay up front for your visit for the services provided. If you provide us with incorrect information, it will then be your responsibility to pay your balance in full and for you to bill your insurance company for reimbursement.

LATE ARRIVAL/APPOINTMENT NO-SHOW
A patient who arrives any time after his/her appointment time is considered a late arrival. A late arrival will be checked in and worked into the schedule if time allows and with the doctor's approval. If the patient is more than 10 minutes late, the appointment may need to be rescheduled. A patient who doesn't show up for the scheduled appointment or cancels a scheduled appointment within 48 hours of the scheduled time maybe charged $50

PAST DUE AND COLLECTION ACCOUNTS
We reserve the right to send accounts with balances that have been outstanding over 90 days from the date of service or the date of payment received from your insurance company, whichever is more, to a collection agency. Please be aware that if a balance remains unpaid, you and/or your immediate family members may be discharged from this practice.

NO ELECTRONIC RECORDING DEVICES
To ensure confidentiality and privacy, any type of electronic recording is strictly prohibited at any location within the office.

The patient's signature (or the signature of the patient's parent or legal guardian) acknowledges that you understand and accept the above information. I have read the above and agree with the terms of this agreement.

Print Name _____ Date _____

Signature _____

V5.22.19

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PATIENT HISTORY RECORD

Date: _____

Name: _____ **Date Of Birth:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone _____ **Email:** _____

Occupation: _____

Emergency Contact Name: _____ **Phone:** _____

Relation: _____

Referring Physician: _____ **Phone Number:** _____

Primary Care Physician: _____ **Phone Number:** _____

Primary Care Clinic Name: _____

Reason for Visit: _____

Other Physician: (Please list names and phone numbers of significant practitioners – specialists, cardiologist, neurologist, etc.)

Name/Specialty: _____ **Phone:** _____

Name/Specialty: _____ **Phone:** _____

Name/Specialty: _____ **Phone:** _____

Name/Specialty: _____ **Phone:** _____

Pharmacy: (NO Mail in pharmacies. Must be local)

Name: Location: Phone:

HISTORY AND INTAKE FORM

Name:_____ **DOB:**_____

Height:_____ **Weight:**_____

Medical History: (please circle all that apply)

___ Anxiety
___ Arthritis
___ Artificial joints
___ Asthma
___ Atrial fibrillation
___ BPH
___ Bone Marrow Transplantation
___ Breast Cancer
___ Colon Cancer
___ COPD
___ Coronary Artery Disease
___ Depression
___ Diabetes
___ End Stage Renal Disease
___ GERD
___ Hearing Loss
___ Hepatitis
___ Hypertension
___ HIV/AIDS
___ Hypercholesterolemia
___ Hyperthyroidism
___ Hypothyroidism
___ Leukemia
___ Lung Cancer
___ Lymphoma
___ Pacemaker
___ Prostate Cancer
___ Radiation Treatment
___ Seizures
___ Stroke
___ Valve Replacement
___ None
___ Other _____

Surgical History: (please circle all that apply)

___ Appendix Removed
___ Bladder Removed
___ Mastectomy Right, ___ Left, ___ Right
___ Lumpectomy ___ Left, ___ Right
___ Breast Biopsy ___ Left, ___ Right
___ Breast Reduction
___ Breast Implants
___ Colectomy: Colon Cancer Resection
___ Colectomy: Diverticulitis Colectomy:
___ IBD
___ Gallbladder Removed
___ Coronary Artery Bypass
___ PTCA
___ Mechanical Valve Replacement
___ Biological Valve Replacement Heart
___ Transplant
___ Joint Replacement, Knee ___ Left, ___ Right
___ Joint Replacement, Hip ___ Left, ___ Right
___ Joint Replacement within last 2 years
___ Kidney Biopsy
___ Kidney Removed ___ Left, ___ Right
___ Kidney Stone Removal
___ Kidney Transplant
___ Ovaries Removed: Endometriosis Ovaries
___ Removed: Cyst
___ Ovaries Removed: Ovarian Cancer Prostate
___ Removed: Prostate Cancer Prostate Biopsy
___ TURP
___ Skin Biopsy
___ Basal Cell Cancer Surgery
___ Squamous Cell Carcinoma Surgery
___ Melanoma Surgery
___ Spleen Removed
___ Testicles Removed ___ Left, ___ Right
___ Hysterectomy: Fibroids
___ Hysterectomy: Uterine Cancer
___ None
Other _____

Name:_____ **DOB:**_____

Ocular History: (Please circle all that apply)

___ Allergic Conjunctivitis

___ Blepharitis

___ Cataract ___Left eye, ___Right eye

___ Corneal Dystrophy ___Left eye, ___Right eye

___ Diabetic Retinopathy, background

___ Dry Eyes ___Left eye, ___Right eye

___ Glaucoma ___Left eye, ___Right eye

___ Macular Degeneration ___Left eye, ___Right eye

___ Macular ERM ___Left eye, ___Right eye

___ Narrow Angles ___Left eye, ___Right eye

___ Ocular Hypertension ___Left eye, ___Right eye

___ Ophthalmic Migraine

___ Pseudoexfoliation

___ Retinal Tear ___Left eye, ___ Right eye

___ Strabismus

___ PVD ___Left eye, ___Right eye

___ Vitreous floaters ___Left eye, ___Right eye

___ None

Other_____

_____

_____

Ocular Surgery: (Please circle all that apply)

___ Blepharoplasty (Left eye, Right eye)

___ Cataract Surgery (Left eye, Right eye)

___ Corneal Transplant (Left eye, Right eye)

___ DSAEK (Left eye, Right eye)

___ Eye Muscle Surgery

___ Intravitreal injections (Left eye, Right eye)

___ LASIK (Left eye, Right eye)

___ LPI (Left eye, Right eye)

___ LTP (Left eye, Right eye)

___ PRK (Left eye, Right eye)

___ Ptosis Repair (Left eye, Right eye)

___ Punctal Plugs ___Left eye, ___ Right eye

___ Strabismus Surgery

___ Retinal Laser ___Left eye, ___ Right eye

___ Trabeculectomy ___Left eye, ___ Right eye

___ Tube Shunt ___Left eye, ___ Right eye

___ Yag Capsulotomy ___Left eye, ___ Right eye

___ None

Other_____

_____

_____

Name:_____ **DOB:**_____

Medications/Vitamins:

(Please List All Current Medication)

_____

_____

_____

_____

_____

_____

_____

_____

Allergies:

(Please List All)

_____

_____

_____

_____

_____

_____

_____

_____

Social History:

(Please Check All That Apply)

Cigarette Smoking:

___ Never Smoked
___ Quit: Former Smoker
___ Smoke Less Than
___ Daily Smokes Daily

Illicit Drug Use:

___ Drug Use
___ IV Drug Use

Alcohol Use:

___ None
___ 1-2 drinks a day
___ 3 or more drinks a day

Recreational Drug Use:

Drug:_____

___1-2 days a Week
___More Than Half the Week
___Daily

Family History:

(Father, Mother, Grandparents, etc.)

___ Blindness
___ Cancer
___ CataractsCVA
___ Diabetes
___ Glaucoma
___ Heart Disease
___ Macular Degeneration
___ Migraine
___ Retinal Detachment
___ Strabismus
___ None

COVID-19 History:

(Please Circle All That Apply)

Vaccinated:

___ YES ___ NO ___Decline to Answer

Positive COVID Test in last 20 Days:

___ YES ___ NO ___ Declined to Answer

Symptoms in the Last 14 Days: (Circle All that Apply)

___ Cough ___Shortness of Breath ___ Fever
___ Vomiting___Muscle/Body Aches ___ Diarrhea
___ Loss of Taste or Smell ___ None

Name:_____ **DOB:**_____

Symptoms You Are <u>Currently</u> Experiencing

	Yes	No
Poor Vision	___	___
Eye Pain	___	___
Tearing	___	___
Redness	___	___
Jaw Pain	___	___
Scalp Tenderness	___	___
Loss of Vision	___	___
Fever	___	___
Chills Weight Loss	___	___
Stuffy Nose	___	___
Ear Ache	___	___
Rapid Heart Rate	___	___
Cough Congestion	___	___
Shortness of Breath	___	___
Upset Stomach	___	___
Diarrhea	___	___
Burning Urination	___	___
Frequent Urination	___	___
Arthritis	___	___
Rash	___	___
Changing Moles	___	___
Headaches	___	___
Seizures	___	___
Anxiety	___	___
Depression	___	___
Insomnia	___	___
Poor Control of Blood Sugar	___	___

Other Symptoms: _____

Portland Oculoplastics, PC

Scot A Sullivan, MD

Provider Notice to Patient Regarding Services That Could be Denied Payment by Medicare and/or Other Insurance Companies.

Medicare will only pay for services that it determines to be "reasonable and necessary" under section 1862(a)(1) of the Medicare law. If Medicare determines that a particular service, although it would be otherwise covered, is "not reasonable and necessary" under Medicare program standards, Medicare or other insurance companies could deny payment for that service.

Patient's Acknowledgment and Agreement To Pay/Insurance Authorization and Assignment

I have been notified by my physician/provider that Medicare or other insurance carrier could deny payment for services performed for me. If Medicare or other insurance carrier denies payment, I agree to be personally and fully responsible for payment. I hereby assign benefits to be paid directly to the doctor, and authorize him/her to furnish information regarding my illness to my insurance carrier.

Print Name_____**Date**_____

Signature of Patient _____

Authorization For Use and Release of Medical Photographs

This is a consent document that has been prepared to help inform you concerning permission to take photographs and to use them for a purpose as defined within this document.

It is important that you read this information carefully and completely. After reviewing, please sign the consent. Medical photographs will be taken before, during and after a surgical procedure or treatment.

I hereby authorize Scot A. Sullivan, M.D. and/or their technician to take and/or use pre-operative, intra-operative, and post-operative photographs for professional medical purposes deemed appropriate including but not limited to release to an insurance company if applicable.

Printed Patient Name_____**Date**_____

Signature of Patient_____

Portland Oculoplastics, PC
10305 SW Park Way, Suite 203
Portland, OR 97225

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I have received a copy of this office's Notice of Privacy Practices. (Available at time of check-in)

_____
(Please Print Name)

_____
(Signature)

_____
(Date)

_____
(Or Signature of Legal Representative) Date:

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

Portland Oculoplastics
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.

If you have any questions about this notice, please contact the designated privacy officer of our office at:	Portland Oculoplastics 10305 SW Park Way, Suite 203 Portland, OR 97225] 503-223-8333

We take our responsibility to safeguard your protected health information very seriously. We value your trust as an important part of our ability to provide you with the best possible medical care. We are dedicated to defending your right to a confidential relationship with your physician.

This notice is intended to inform you of how we protect, use, and disclose your information, as well as to explain your right to control these disclosures.

Your Health Information

We may use and disclose health information about you without your permission for the following purposes:

1. We may disclose your information for **treatment purposes and to coordinate your medical care.**
2. We may disclose your information **to ensure that you receive insurance benefits.**
3. We may disclose your information internally **to enhance the operation of our practice.** This includes our commitment to reviewing the quality of care we provide.
4. We may disclose your information **to comply with a limited number of legal requirements**, as outlined in this notice.

Additional information regarding each of these disclosures is provided in this notice. In any case, we will only disclose the minimum amount of information necessary for the purpose it was requested.

Our Duties

We are required by law to keep your information private. We must also provide you with this Notice and abide by its terms. We may need to revise our privacy practices from time to time. We expressly reserve the right to change our Notice of Privacy Practices and make the new terms effective for all information covered by our Notice. If such changes occur, we will let you know about the new terms by providing a copy of the changes.

Your Privacy Rights

Please note that you are entitled to specific rights regarding the use and disclosure of your information. We have listed your rights below:

Right to Inspect and Copy

You have the right to inspect and copy your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a written request to our designated contact to inspect and/or copy your information. If you request a copy of your information, we may charge a fee for the costs of copying, mailing, or other associated supplies. You may also choose to receive a copy of your health information in electronic form.

We may deny your request to inspect and/or copy information in certain limited circumstances. If you are denied access to your health information, you can ask that the denial be reviewed. If the law requires such a review, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

Right to Amend

If you believe our records contain errors, you may make a written request that they are amended. We reserve the right to review your request and can decline to amend the record. We are required to place a copy of your proposed amendment in the record, even when we do not agree to amend the record itself.

We may deny your request for an amendment if we did not create the information unless the person or entity that created the information is no longer available to make the amendment.

Right to Request Restrictions

You have the right to request restrictions on the use and disclosure of your information. We are not required to agree to your request. If we do agree, we will comply to the best of our ability unless the information is needed to provide you with emergency treatment. To request restrictions, you may complete and submit the Request for Restriction on Use/Disclosure of Medical Information to our designated Privacy Officer/Contact. If your restriction invalidates your insurance coverage, we may require you to execute a waiver of insurance benefits and a payment agreement.

Right to Request Confidential Communications

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you may complete and submit the form Request for Restriction on Use/Disclosure of Medical Information to our designated Privacy Officer/Contact. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. To obtain such a copy, contact our designated Privacy Officer/Contact.

Right to an Accounting of Disclosures

You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment, and health care operations.

To obtain this list, you must submit your request in writing to our designated Privacy Officer/Contact. It must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what format you want the list (for example, on paper or electronically).

The first list you request within 12 months will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved, and you may choose to withdraw or modify your request at that time before any charges are incurred.

Complaints and Investigations

We have developed procedures for investigating any complaints or concerns you may have regarding our use and disclosure of your information or any other complaint regarding our services. The law allows you to contact the Secretary of the Department of Health and Human Services with complaints about our use and disclosure of information.

You may also contact our on-site Privacy Officer/Contact, who is dedicated to investigating complaints regarding the use and disclosure of information in our care. We will not, and legally cannot, retaliate against you for any complaint.

Types of Use and Disclosure of Your Protected Health Information

We may disclose your information for the following purposes without your consent:

For Treatment Purposes

We may disclose information needed for the provision, coordination or management of health care and related services, including the coordination between our office and a third party, such as a consultation between medical providers or a referral from our office to another provider. Personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as phoning prescriptions to your pharmacy, scheduling lab work, and ordering X-rays. Family members and other healthcare providers may be part of your medical care outside this office and may require information about you that we have.

For Payment

To obtain reimbursement from your insurer, we may be required to disclose your information. This may be necessary for determining your eligibility for coverage and adjudication of claims, billing, claims management, and collections activities. We may also be required to disclose your information to your insurer to review the medical necessity, coverage, appropriateness, or justification of our charges.

For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you will receive to obtain prior approval or determine whether your plan will cover the treatment. You have the right to restrict disclosures of your PHI to a health plan if you have paid out-of-pocket in full for the treatment.

For Health Care Operations

We may use and disclose health information about you to run the office and make sure that you and our other patients receive quality care. Healthcare operations may include:

- Quality assessment and improvement activities
- Reviewing the competence or qualifications of healthcare professionals or evaluating practitioner and provider performance
- Conducting training programs, accreditation, certification, licensing, or credentialing activities
- Arranging for or conducting a medical review, legal services, or auditing functions, including fraud and abuse detection and compliance programs
- Managing and operating our practice, including activities such as customer service and complaint resolution

Appointment Reminders

We may contact you (via voicemail messages, postcards, or letters) as a reminder that you have an appointment for your treatment or medical care at our office.

Treatment Alternatives

We may tell you about or recommend possible treatment options or alternatives that may interest you. We also may tell you about health-related products or services that may be of interest to you.

Marketing Health-Related Services

We will not use your health information for marketing communications without your written, prior authorization. We will not sell your PHI to another organization for marketing or any other purposes.

Special Situations

We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

1. **To Avert a Serious Threat to Health or Safety**. We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
2. **Required By Law.** We will disclose health information about you when required to do so by federal, state, or local law.
3. **Research.** We may use and disclose health information about you for research projects subject to a unique approval process. We will ask you for your permission if the researcher will have access to your name, address, or other information that reveals who you are or will be involved in your care at the office.
4. **Organ and Tissue Donation.** If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation, or an organ donation bank, as necessary to facilitate such donation and transplantation.
5. **Military, Veterans, National Security, and Intelligence**. Suppose you are or were a member of the armed forces, or part of the national security or intelligence communities. In that case, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.
6. **Workers' Compensation**. We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.
7. **Public Health Risks**. We may disclose health information about you for public health reasons to prevent or control disease, injury, or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications, or problems with products.
8. **Health Oversight Activities**. We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for specific state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.
9. **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.
10. **Law Enforcement**. We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons, or similar process, subject to all applicable legal requirements.
11. **Coroners, Medical Examiners, and Funeral Directors**. We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death.
12. **Information Not Personally Identifiable**. We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.
13. **Family and Friends**. We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we allow you to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances that you would not object based on our professional judgment.
14. **Deceased Person's PHI** may be disclosed by our practice to family or others involved in the person's care or payment for care, unless our practice knows the deceased preferred that certain people not receive the PHI. Disclosures are limited to the PHI directly relevant to the person's involvement.

For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room during treatment or while treatment is discussed.

In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care.

Other Uses and Disclosures of Health Information

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written *Authorization*. We must obtain your *Authorization* separate from any *Consent* we may have obtained from you.

If you give us *Authorization* to use or disclose health information about you, you may revoke that *Authorization*, **in writing**, at any time.

If you revoke your *Authorization*, we will no longer use or disclose information about you for the reasons covered by your written *Authorization*. However, we cannot take back any uses or disclosures already made with your permission.

You have the right to be notified following a breach of your PHI by our practice.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact:

Portland Oculoplastics
10305 SW Park Way, Suite 203 Portland, OR 97225]
503-223-8333

You will not be penalized for filing a complaint.