PORTLAND
OCULOPLASTICS
SCOT A. SULLIVAN, M.D.
10305 SW Park Way, Suite 203
Portland, OR 97225
503-223-8333

Appointment

Day:_____

Date:_____

Time:_____

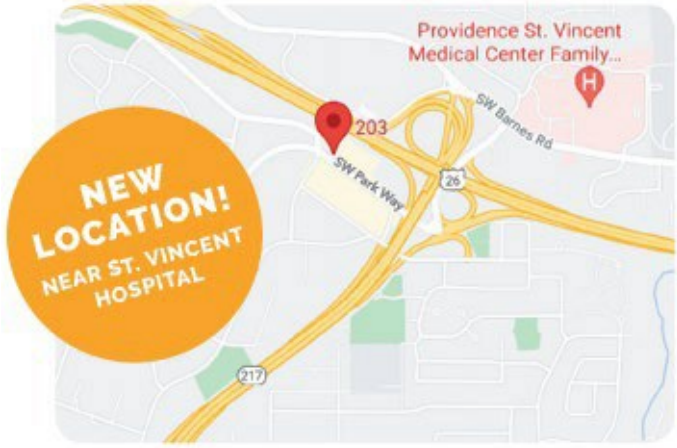
Patient Name _____

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. ALL APPOITNMENTS MUST BE CONFRIMED NO LESS THAN 2 BUSINESS DAYS PRIOR THE APPOINTMENT. Please contact us if there are any changes to your contact information.

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.

All cosmetic appointment fees are due same day.

All cosmetic surgery fees are due 2 weeks prior to surgery date.

ALL credit or debit card payments are subject to a 3.95% surcharge . To avoid surcharge fees, cash, check or ACH payment is accepted.

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, NO-SHOW & CALCELLATIONS

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 or show up for the scheduled appointment or cancels a scheduled appointment within 48 hours of the scheduled time maybe charged $50. Surgery cancellation within 30 days range from $250-$500

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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97225

PATIENT HISTORY RECORD

Date:_____

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

Address:_____

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

Phone:_____ **Mobile Carrier:**_____

Email:_____ **Occupation:**_____

Emergency Contact:_____ **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: (check 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: (check 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: (check 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: (check 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 & Daily Vitamins:

(Please List All Current Medication)

_____

_____

_____

_____

_____

_____

_____

_____

_____

Drug 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
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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)

_____

_____