EYELID & FACIAL CONSULTANTS
Adham B. al Hariri, M.D.
Michael W. Worley, M.D.
Austin M. Pharo, M.D.

PATIENT INFORMATION

Which doctor is the patient here to see? ☐ Dr. Hariri ☐ Dr. Worley ☐ Dr. Pharo Date of Visit: ____________

Patient's Name: ______________________________ Sex: ☐ Male ☐ Female

Date of Birth: ____________ Age: ______ Social Security #: ____________

Address: ____________ City: ____________ State: ______ Zip: ______

Home Phone: ____________ Cell Phone: ____________ Email: ____________

Is the patient personally responsible for the payment of his/her fees? ☐ Yes ☐ No If not, who is? ____________

Insurance Policy Holder's Name: ____________ Self/Relationship: ____________ DOB: ____________

Primary Medical Insurance: ______________________________

Secondary Medical Insurance: ______________________________

Patient's Employer: ____________ Occupation: ____________

Employer's Address: ____________ Employer's Phone Number: ____________

Patient's Marital Status: ☐ Single ☐ Married ☐ Domestic Partnership ☐ Divorced ☐ Widowed

Emergency Contact's Name: ____________ Relationship to Patient: ____________

Emergency Contact's Address: ____________ Emergency Contact's Phone #: ____________

How did the patient hear about us? *(Please check all that apply)*

☐ Doctor Referral *(Name)* ____________ ☐ Aesthetician ☐ Website ☐ TV ☐ Email

☐ Friend/Relative *(Name)* ____________ ☐ Yellow Pages ☐ Magazine/Newspaper ☐ Radio

COMPLETE ONLY IF PATIENT IS UNDER 18 YEARS OF AGE

Name of Patient's Father: ____________ Father's DOB: ____________

Father's Employer: ____________ Father's Phone #: ____________

Name of Patient's Mother: ____________ Mother's DOB: ____________

Mother's Employer: ____________ Mother's Phone #: ____________

PLEASE SIGN BELOW

Patient's or Parent's Signature: ______________________________ Date: ____________

Thank you for choosing our office for your healthcare needs. Please complete the medical questionnaire in full to assist us with your medical evaluation.

PATIENT MEDICAL HISTORY QUESTIONNAIRE

PATIENT NAME	**DATE OF BIRTH**	
REASON FOR CONSULTATION		

LIST ALL TREATING PHYSICIANS (PLEASE INCLUDE PHONE NUMBERS)

	First and Last Name	Phone Number
1		
2		
3		
4		
5		

LIST ALLERGIES TO MEDICATIONS AND REACTIONS

	MEDICATION NAME	REACTION
1		
2		

REVIEW OF SYSTEMS:

Do you currently have any problems in the following areas?

		Yes	No		Yes	No
Allergic/Immunologic				**Ears, Nose, Mouth, Throat**		
	Hay fever symptoms			Chronic cough		
	Head allergy symptoms			Dry throat/mouth		
	Seasonal allergies			Pain with chewing		
Cardiovascular (Heart/Blood Vessels)				Post-nasal drip		
	High blood pressure			Runny nose		
	Pace Maker			Sinus congestion		
	Other			**Endocrine**		
Constitutional Symptoms				Diabetes		
	Fever			Thyroid disorders		
	Muscle Pain			Other		
	Weight Loss			**Gastrointestinal (Stomach/Intestines)**		
Eyes				**Genitourinary**		
	Blurred Vision			Genitals/kidney/bladder		
	Burning			**Hematologic/lymphatic**		
	Chronic infection of eye or lid			Blood		
	Distorted vision (halos)			Lymph nodes		
	Double vision			Swelling		
	Dryness			**Integumentary (Skin or Breast)**		
	Excess tearing/watering			**Neurological**		
	Occasional tearing			**Psychiatric**		
	Eye pain or soreness			Depression		
	Flashing lights			Other		
	Fluctuating visual acuity			**Respiratory**		
	Glare/Light sensitivity			Asthma (childhood/adult)		
	Loss of side vision			Chronic Bronchitis		
	Loss of vision			**Skeletal**		
	Mucous discharge			Back Pain		
	Redness			Joint Pain		
	Tired eyes			Muscle Pain		
	Cataracts					
	Prominent eyes					
	Drooping eyelids					
	Lazy eye					
	Crossed eye					
	Glaucoma					
	Macular degeneration					
	Keratoconus					
	Floaters					
	Foreign body sensation					
	Itching					
	Sties/Chalazion					

PAST HISTORY

List all medications and vitamins you currently take

Medication Name	Dose	Frequency

List all eye medications and/or ointments you currently take or use

Medication Name	Dose	Frequency

List all illnesses (list specific disease)

List any surgeries you have had including cosmetic and eye procedures

Thank you for choosing our office for your healthcare needs. Please complete the medical questionnaire in full to assist us with your medical evaluation.

PATIENT MEDICAL HISTORY QUESTIONNAIRE

FAMILY HISTORY includes Mother, Father, Sister, Brother, Grandparents, Aunt, Uncle	Yes	No	Relationship to patient	Maternal	Paternal
DISEASE					
Allergies					
Asthma					
Blindness					
Cataract					
Eczema					
Glaucoma					
Macular Degeneration					
Retinal Detachment					
Retinoblastoma					
Arthritis					
Cancer					
Diabetes					
Heart Attacks					
High blood pressure					
Keratoconus					
Kidney Disease					
Lupus					
Sjogren's Syndrome					
Stroke					
Thyroid Disease					
Tuberculosis					
Other					

SOCIAL HISTORY

Current Occupation:

	Yes	No	Comments
Do you drink alcohol?			
If YES, how many glasses per day?			
Do you smoke?			
If YES, how many packs per day?			
Transmissible blood bourne diseases (HIV, Hepatitis, Herpes)?			

I have completed the medical questionnaire and to the best of my knowledge confirm the accuracy of the answers.

Patient Signature:	Date:
Guardian of Patient:	Date:
Physician Signature:	Date:

EYELID & FACIAL CONSULTANTS

Adham B. al Hariri, M.D.
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SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT, ACKNOWLEDGEMENT OF PRIVACY PRACTICES, DISCLOSURE OF FINANCIAL INTEREST

1. **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to Eyelid & Facial Consultants for services furnished by Eyelid & Facial Consultants. I authorize any holder of medical information about me to release to Medicare and its agents any information needed to determine these benefits or the release of medical information necessary to pay the claim. If I have other insurance coverage, my signature authorizes releasing the information to the insurer or agency shown. Eyelid & Facial Consultants accepts the Medicare allowable determination of the carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services.
2. **PARTICIPATING INSURANCE AND RELEASE OF INFORMATION:** I understand that Eyelid & Facial Consultants may use and disclose medical information about me for services and procedures so they may be billed and collected from an insurance agency or other third party. Eyelid & Facial Consultants may also tell my health plan and/or referring physician about a treatment I am going to receive to obtain prior approval or to determine whether my plan will cover the treatment, to facilitate payment, or the like.
3. **NON-PARTICIPATING WITH PATIENT'S INSURANCE:** The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to be by Eyelid & Facial Consultants if I belong to a plan that Eyelid & Facial Consultants does not participate with.
4. **NON-COVERED SERVICES:** The undersigned accepts full financial responsibility for all items and services which are determined by my insurance plan not to be covered. The undersigned agrees to cooperate with Eyelid & Facial Consultants to obtain necessary healthcare service plan authorizations.
5. **FINANCIAL AGREEMENT:** I agree that in return for the services provided to the patient by Eyelid & Facial Consultants I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Eyelid & Facial Consultants for payment.
6. **FINANCE CHARGES:** I agree to pay a finance charge of 1% per month, compounded, for any balance I am responsible for which is over 60 days old. I also agree to pay for any returned check fees incurred by Eyelid & Facial Consultants. It is the policy of Eyelid & Facial Consultants to charge a fee no less than $25.00 for checks that are returned. I also agree that if I am the parent/guardian bringing a child in for treatment that I am responsible for all fees incurred by the child. If an account is sent to a collection agency or attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. 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 Eyelid & Facial Consultants. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Eyelid & Facial Consultants. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.
7. **ACKNOWLEDGEMENT OF PRIVACY PRACTICES:** I hereby acknowledge that I have received a copy of the Notice of Privacy Practices for Eyelid & Facial Consultants. There is also a copy posted in the office. I understand that if I have questions or complaints regarding my privacy rights that I may contact the Privacy Officer.
8. **CONSENT:** I hereby authorize the doctors and staff of Eyelid & Facial Consultants to administer or perform medical treatment including procedures or services as the may deem necessary or reasonable, including laboratory services and diagnostic procedures. Additionally, I authorize Eyelid & Facial Consultants to obtain my medication history.
9. **DISCLOSURE OF FINANCIAL INTEREST:** Louisiana law requires physicians to disclose to a patient when the physician refers the patient to another healthcare provider or facility of which the physician has a financial interest. The purpose of this disclosure is to notify you that Michael W. Worley, MD has an ownership interest in Advanced Surgery Center of Metairie, LLC. If you are referred to this entity by Michael W. Worley, MD and have questions, please discuss this with your physician directly. You have the right to choose a different entity or choose not to receive the services by letting your physician know.

______________________________	______________________________
Patient or Legal Guardian/Representative's Name (PRINT)	*Relationship to Patient*
______________________________	______________________________
Patient or Legal Guardian/Representative's Signature	*Date and Time*

EYELID & FACIAL CONSULTANTS

PATIENT PHOTOGRAPHIC/VIDEO AUTHORIZATION AND RELEASE

I consent to the filming and taking of photographs by the Eyelid & Facial Consultants staff of me or parts of my face in connection with cosmetic surgery or procedure(s) to be performed by Dr. Adham B. al Hariri, Dr. Michael W. Worley and/or Dr. Austin M. Pharo.

I understand that such photographs and/or video may be utilized or shown in any print, visual or electronic media for the purpose of physician education.

Neither I, nor any member of my family, will be identified by name in any publication. I understand that in some circumstances the photographs may portray features which could my identity recognizable.

I understand that I have the right to revoke this authorization in writing at any time, but if I do so, it won't have any effect on any actions taken prior to my revocation. If I do not revoke this authorization, it will expire ten years from the date written below. I understand that I may refuse to sign this authorization and such refusal will have no effect on the medical treatment I receive from Dr. Adham B. al Hariri, Dr. Michael W. Worley and/or Dr. Austin M. Pharo.

I understand that the information disclosed, or some portion thereof, may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

I release and discharge the treating physician, and all parties from all rights that I may have in the photographs and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of the photographs.

If the patient is a minor, I am the patient's representative parent, guardian or conservator, and I am authorized to sign this consent on his/her behalf.

☐ **Release photos to be used in physician and patient education in the office.**

☐ **Release photos to be used in external marketing (ie. print ads, website).**

***** I GRANT THIS REQUEST AS A VOLUNTARY CONTRIBUTION IN THE INTEREST OF PUBLIC EDUCATION AND CERTIFY THAT I HAVE READ THE ABOVE AUTHORIZATION AND RELEASE AND FULLY UNDERSTAND ITS TERMS.**

Patient or Legal Guardian/Representative's Name (PRINT)	*Relationship to Patient*
Patient or Legal Guardian/Representative's Signature	*Date*
Witness' Name (PRINT)	
Witness' Signature	*Date*

3715 Prytania Street
Fifth Floor, Suite 504
New Orleans, LA 70115

Phone: (504) 895-3223
Fax: (504) 895-3224

Health Insurance Portability and Accountability Act of 1996

Notice of Privacy Practices

Effective: October 20, 2014

NOTICE OF PATIENT 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 our Privacy Officer at the number listed at the end of this Notice.

Each time you visit a healthcare provider; a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, a plan for future care or treatment, and billing related information. This Notice applies to all of the records of your care generated by your health care provider.

Our Responsibilities

Eyelid & Facial Consultants is required by law to maintain the privacy of your health information and to provide you with a description of our legal duties and privacy practices regarding your health information. The current Notice will be posted in the waiting area and on our website at www.efcnola.com. The notice will include the effective date. We will make our best effort to ensure you have an opportunity to get a copy of
this notice and we request that you acknowledge this with your signature.

We are required by law to abide by the terms of this Notice and notify you if we make changes to this Notice, which may be at any time. Changes to the Notice will apply to your medical information that we already maintain as well as new information received after the change occurs. If we change our Notice, it will it will be made available to anyone who asks for it, and be posted in the waiting area and on our website at www.efcnola.com.
You may also request that a revised Notice be sent to you in the mail or you may ask for one at your next appointment or appropriate visit. This Notice will also serve to advise you as to your rights with regard to your medical information.

How We May Use and Disclose Medical Information About You.

The following categories describe examples of the way we use and disclose medical information:

For Treatment: We may use medical information about you to provide, coordinate and manage your treatment or services. We may disclose medical information about you to other doctors, nurses, technicians (e.g. clinical laboratories or imaging companies), medical students, or other personnel who are involved in your care. We may communicate your information either orally or in writing by mail or facsimile. We may also provide a subsequent healthcare provider with copies of various reports that should assist him or her in treating you. For example, your medical information may be provided to a physician to whom you have been referred so as to ensure that the physician has appropriate information regarding your previous treatment and diagnosis.

For Payment: We may use and disclose medical information about your treatment and services to bill and collect payment from you, your insurance company or a third party payer. For example, we may need to give your insurance company information before it approves or pays for the health care services we recommend for you.

For Health Care Operations: We may use or disclose, as needed, your health information in order to support our business activities. These activities may include, but are not limited to quality assessment activities, employee review activities, licensing, legal advice, accounting support, information systems support and conducting or arranging for other business activities. In addition, we may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment by telephone or reminder card.

Business Associates: There are some services provided in our organization through contracts with business associates. Examples include software support, billing, collections. If these services are contracted, we may disclose your health information to our business associate so that they can perform the job that we have asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information through a written contract., In addition, business associates are individually required to abide by the HIPAA Rules.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object:

We also may use and disclose your health information as set forth below. You have the opportunity to agree or object to the use or disclosure of all or part of your health information in these instances. If you are not present or able to agree or object to the use or disclosure of the health information (such as in an emergency situation), then your clinician may, using professional judgment, determine whether the disclosure is in your best interest. In this case,

only the information that is relevant to your health care will be disclosed.

Individuals Involved in Your Care or Payment for Your Care: Unless you object, we may release medical information about you to a friend or family member who is involved in your medical care or who helps to pay for your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

Future Communications: We may communicate to you via newsletters, mailings or other means regarding treatment options, information on health-related benefits or services; to remind you that you have an appointment for medical care; or other community based initiatives or activities in which our facility is participating. If you are not interested in receiving these materials, please contact our Privacy Officer.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Object

We may use or disclose your health information in the following situations without your authorization or without providing you with an opportunity to object. These situations include:

As required by law. We may use and disclose health information to the following types of entities, including but not limited to:

- Food and Drug Administration
- Public Health or Legal Authorities charged with preventing or controlling disease, injury or disability
- Correctional Institutions
- Workers Compensation Agents
- Organ and Tissue Donation Organizations
- Military Command Authorities
- Health Oversight Agencies
- Funeral Directors, Coroners and Medical Directors
- National Security and Intelligence Agencies
- Protective Services for the President and Others
- Authority that receives reports on abuse and neglect

Law Enforcement/Legal Proceedings: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

State-Specific Requirements: Many states have requirements for reporting, including population-based activities relating to improving health or reducing health care costs.

Your Health Information Rights

Although your health record is the physical property of the Eyelid & Facial Consultants that compiled it, you have the right to:

Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. We ask that you submit these requests in writing. Usually, this includes medical and billing records, but does not include psychotherapy notes or information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review. Requests for access to and copies of your medical information must be submitted to us in writing. There is no charge at this time.

Amend: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information by submitting a request in writing. You have the right to request an amendment for as long as we keep the information. We may deny your request for an amendment and if this occurs, you will be notified of the reason for the denial.

An Accounting of Disclosures: You have the right to request an accounting of our disclosures of medical information about you except for certain circumstances, including disclosures for treatment, payment, health care operations or where you specifically authorized a disclosure. Eyelid & Facial Consultants will provide the first accounting to you in any 12-month period without charge. The cost for subsequent requests for an accounting within the 12-month period will be $0.00. We ask that you submit these requests in writing.

Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a procedure that you had. We ask that you submit these requests in writing. *Except under specific circumstances, we are not required to agree to your request.* If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment or is required by law. We must agree to restrict the disclosure of protected health information to a health plan for purposes of carrying out payment or health care operations (as defined by HIPAA) if the information pertains solely to a health care item or service for which we have been paid by you out-of-pocket, and in full.

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. We will agree to the request to the extent that it is reasonable for us to do so. For example, you can ask that we use an alternative address for billing purposes. We ask that you submit these requests in writing.

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 this notice electronically, you are still entitled to a paper copy of this notice. To exercise any of your rights, please obtain the required forms from the Privacy Officer and submit your request in writing.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with us by calling (504) 895-3223 and asking for the Privacy Officer or by contacting the Secretary of the Federal Department of Health and Human Services. All complaints must be also submitted in writing. You will not be penalized for filing a complaint.

Other Uses of Medical Information

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. However, we are unable to take back any disclosures we have already made with your permission and we are required to retain our records of the care that we provided to you.

Privacy Officer: Office Manager
Telephone Number: (504) 895-3223