OphthalmicPlasticSurgery
PLLC

Edward J. Wladis, M.D., FACS
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APPOINTMENT: Date: _____Time: _____AM/PM

Dear Patient:

We would like to welcome you to our office, and hope the enclosed information will help you become more familiar with our office. In order to speed up your check-in process we are enclosing our new visit forms. Please fill out each form and sign the Financial Agreement and Assignment of Benefits and Patient Consent for Use and Disclosure of Protected Health Information. Please bring these forms along with your medical insurance card(s), to your appointment. ***WE ASK THAT YOU DO NOT MAIL THESE FORMS BACK TO US AS OUR MAIL SERVICE IS NOT RELIABLE.***

All copays are due on the day of service. Please come prepared with cash, check or credit card (*We accept Visa or Mastercard*). You will be responsible for any charges not covered by your insurer. If you need to check if we accept your insurance plan(s), please contact our billing department @ **(518) 459-5397**.

If you are unable to keep your appointment, kindly notify our office **WITHIN 24 hours** so that we may offer your time slot to another patient. **If you are more than 15 minutes late, your appointment may need to be rescheduled.**

For your convenience we are also enclosing directions to our office. **Please keep in mind we recently moved to a new location (15 Vista Blvd, Slingerlands, NY 12159) as of December 2022**. If you would also like to get further information on our office, please visit our practice website at http://www.eyefacialplasticsurgery.com.

We look forward to seeing you. If you have any questions please feel free to call us @ **(518) 533-6540**.

DIRECTIONS:

From NYS THRUWAY: Exit 24 to I90E to EXIT 4, Rte 85 towards Voorheesville/Slingerlands.
From I90: EXIT 4, Rte 85 towards Voorheesville/Slingerlands
From 787: Boston/Buffalo exit to I90W, EXIT 4, Rte. 85 towards Voorheesville/Slingerlands
From I87Northway: Exit 1E onto I90E, EXIT 4, Rte 85 towards Voorheesville/Slingerlands

Then From the I-90 Exit 4 (Rte 85 towards Voorheesville/Slingerlands):
Continue on Rte 85 (*THIS ROUTE MERGES INTO A 2-LANE ROAD*), at the ***FIRST TRAFFIC CIRCLE*** stay in left lane to continue on to Rte 85, at the ***SECOND TRAFFIC CIRCLE*** stay in the right lane to continue onto Rte 85. Staying in the right lane, at the ***THIRD TRAFFIC CIRCLE*** take the first exit off the circle towards ***VISTA BLVD***, once on Vista Blvd take the first right-hand turn and continue to the end, then take right-hand turn into our parking lot, we are the first building to your left. **(15 Vista Blvd, Slingerlands, NY 12159).**

OPHTHALMIC PLASTIC SURGERY

PATIENT INFORMATION

Patients Name:
(First, Middle, Last)

M____F____ **Date of Birth** **SSN**

Street Address:

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

Home: **Cell:**

Occupation: **Employer:**

Work Address: **Work Phone:**

Emergency Contact: **Relationship:**

Home Phone: **Cell or Work Phone:**

INSURANCE

Primary: _____

Secondary: _____

Subscriber's Name: _____Relationship to patient: _____DOB: _____

If workers Compensation: Provide case number: _____

Which Doctor referred you to us? _____

Who is your primary (family) doctor?_____

Note: *Please remember, <u>you are responsible</u> for obtaining a referral from your primary (family) physician for evaluation and treatment, if required by your insurer. Please bring your insurance card with you on each date of service, and inform the staff of any changes. Payment is due on the date of service for any copay or "self-pays" (if no insurance or a non-covered service).*

HISTORY SHEET

Patient Name **DOB** **MR#** **Date of Exam**

PLEASE COMPLETE (all responses will be kept confidential)

Referring Doctor (full name) +Telephone No.

Primary Doctor (full name) +Telephone No.

Cardiologist (full name) + Telephone No.

Height: **Weight:**

MEDICAL HISTORY: **Please List below (or circle NONE if applicable):

HEALTH PROBLEMS: NONE

1. 2. 3. 4. Additional:

PREVIOUS SURGERY: NONE

1. 2. 3. 4. Additional:

FAMILY HISTORY: (Please circle if a family member has any of the following diseases):

HEART DIABETES EYE Additional:

SOCIAL HISTORY:

Do you smoke tobacco? NO YES If yes, how much? _____

Do you drink alcohol? NO YES If yes, how much? _____

Are you currently working? NO YES If yes, what type of job? _____

Do you currently have any problems of the following areas? If YES, circle, and provide additional information as needed:	**NO YES**	**DETAILS**
EYES (poor vision, pain, tearing, redness, etc)	NO / YES	
GENERAL/ CONSTITUTIONAL (fever, weight loss, weight gain, unusually tired, etc)	NO / YES	
EARS, NOSE, THROAT (hard of hearing, stuffy nose, earaches, sinus,dry mouth, etc)	NO / YES	
CARDIOVASCULAR (high BP, racing pulse, etc)	NO / YES	
RESPIRATORY (congestion, wheezing, short of breath, etc)	NO / YES	
GASTROINTESTINAL (stomach upset, diarrhea, constipation, etc)	NO / YES	
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, etc)	NO / YES	
FEMALES (are you pregnant? Nursing)	NO / YES	
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, etc)	NO / YES	
SKIN (pimples, warts, growths, rash, etc)	NO / YES	
NEUROLOGIC (numbness, headache, seizures, weakness, etc)	NO / YES	
PSYCHIATRIC (anxiety, depression, insomnia, etc)	NO / YES	
ENDOCRINE (diabetes, hypothyroid, hyperthyroid, etc)	NO / YES	
BLOOD/LYMPH (bleeding, anemia, etc)	NO / YES	
ALLERGIC/IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, etc)	NO / YES	

MEDICATION SUMMARY SHEET

Patient Name	DOB	MR#	Date of Exam

PATIENT: PLEASE COMPLETE:

Pharmacy: _____ **Telephone** (____) _____

ALLERGIES: (Circle: NONE OR LIST BELOW)

1. _____ REACTION: _____
2. _____ REACTION: _____
3. _____ REACTION: _____
4. _____ REACTION: _____

EYE DROPS/OINTMENTS	Dose/Frequency	Date Stopped	Reviewer/Date

MEDICATIONS (Prescription)	Dose/Frequency	Date Stopped	Reviewer/Date

OVER THE COUNTER	Dose/Frequency	Date Stopped	Reviewer/Date

DO YOU TAKE ASPIRIN? YES NO
DO YOU TAKE BLOOD THINNERS? YES NO
(Such as Plavix, Coumadin, or Other)
DO YOU HAVE A PACEMAKER? YES NO

_____
Reviewed with patient

OPHTHALMIC PLASTIC SURGERY, PLLC

Edward J. Wladis, MD/Michael I. Rothschild/Dale R. Meyer, MD/Charlotte L. Marous, MD

Financial Agreement and Assignment of Benefits

For Medicare or Senior Advantage

I request that payment of authorized Medicare benefits be made on my behalf to **Ophthalmic Plastic Surgery (Doctors Edward J. Wladis, Michael I. Rothschild, Dale R. Meyer and Charlotte L. Marous)** for services furnished me by **Ophthalmic Plastic Surgery (Doctors Edward J. Wladis, Michael I. Rothschild, Dale R. Meyer and Charlotte L. Marous)**. I authorize the holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine or the benefits payable to related services.

I understand my signature requests that payment be made and authorize 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 authorized releasing to the insurer or agency shown.

Ophthalmic Plastic Surgery (Doctors Edward J. Wladis, Michael I. Rothschild, Dale R. Meyer and Charlotte L. Marous) accepts the charge determination of the Medicare carrier, Blue Shield of Western NY, or applicable DMERC, as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

For Medigap

I understand that if Medigap policy or other health insurance 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 benefits be made on my behalf to **Ophthalmic Plastic Surgery (Doctors Edward J. Wladis, Michael I. Rothschild, Dale R. Meyer and Charlotte L. Marous)**.

For Other Insurance

I hereby authorize payment of my medical and surgical insurance benefits to **Ophthalmic Plastic Surgery (Doctors Edward J. Wladis, Michael I. Rothschild, Dale R. Meyer and Charlotte L. Marous)**. I understand that I am financially responsible for any charges, whether or not paid by said insurance. If co-payment and/or deductible are designated by my insurance company or health plan, I agree to pay them to **Ophthalmic Plastic Surgery (Doctors Edward J. Wladis, Michael I. Rothschild, Dale R. Meyer and Charlotte L. Marous)**. I authorize **Ophthalmic Plastic Surgery (Doctors Edward J. Wladis, Michael I. Rothschild, Dale R. Meyer and Charlotte L. Marous)** to release any information required to process any and all claims for reimbursement on my behalf. A copy of the authorization may be used in place of the original.

_____

Beneficiary Signature or Authorized Party Date

_____

Beneficiary Name (Print)

OPHTHALMIC PLASTIC SURGERY, PLLC
Patient Consent for Use and Disclosure
Of Protected Health Information

With my consent, Ophthalmic Plastic Surgery of Albany may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Ophthalmic Plastic Surgery of Albany Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Ophthalmic Plastic Surgery of Albany reserves the right to revise its Notice of Privacy Practices at anytime.

With my consent, Ophthalmic Plastic Surgery of Albany may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations (TPO), such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Ophthalmic Plastic Surgery of Albany may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With my consent, Ophthalmic Plastic Surgery of Albany may photograph me for medical documentation of my condition, treatment, payment and healthcare operations. (TPO)

I have the right to request that Ophthalmic Plastic Surgery of Albany restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Ophthalmic Plastic Surgery of Albany's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Ophthalmic Plastic Surgery of Albany may decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian Date

_____

Print Name of Patient or Legal Guardian