EYE & FACIAL
PLASTIC SPECIALISTS
Dr. Donald Hollsten & Dr. Jordan Hollsten

New Patient Information

PATIENT INFORMATION

Last Name _____ **First Name** _____ **MI** _____
Gender (circle one) Male Female Non-Binary Prefer not to say
Date of Birth _____ **SSN** _____
Marital Status (circle one) Single Married Divorced Widowed Partner
Mailing Address _____ **Suite/Apt.** _____
City _____ **State** _____ **Zip** _____
Preferred Language _____ **Email** _____
Home Phone _____ **Cell Phone** _____

Preferred Pharmacy _____
Pharmacy Location_____ **Pharmacy Phone** _____
Emergency Contact _____ **Emergency Phone** _____
Relationship to Patient _____

PRIMARY INSURANCE

☐ Check this box if Patient details are the same as Guarantor

Insurance _____ **Subscriber ID #** _____ **Group #** _____
Claims Address (on back of card): **Street** _____
City/State/Zip _____
(Please fill out with information of Primary Guarantor if different from patient)
Last Name _____ First Name _____ MI _____
Date of Birth _____ SSN _____

SECONDARY INSURANCE

☐ Check this box if Patient details are the same as Guarantor

Insurance _____ **Subscriber ID #** _____ **Group #** _____
Claims Address (on back of card): **Street** _____
City/State/Zip _____
(Please fill out with information of Primary Guarantor if different from patient)
Last Name _____ First Name _____ MI _____
Date of Birth _____ SSN _____

REFERRAL INFORMATION

Referring Physician _____ OR **Other Referral** _____
Primary Care Physician _____ **Cardiologist** _____

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OFFICE POLICIES

I understand the following:

→ CO-PAYMENT/deductible is due at the time of the appointment.

→ I acknowledge financial responsibility for any balance(s) not paid by my insurance, including deductibles, co-payments, co-insurance, and/or any non covered service(s), etc; failure to comply could result in a collection debt.

→ I understand that visual field exams will not be performed on the same day as an office visit exam.

→ A $75 non-refundable fee will be assessed for failure to show for a scheduled appointment without notifying Dr. Hollsten's office at least 24 hours in advance.

→ A $350 non-refundable fee will be assessed for failure to show for a scheduled surgery without notifying Dr. Hollsten's office at least 2 weeks in advance.

→ I authorize release of all information necessary to secure insurance payment.

→ Any missing or incorrect information might result in problems with insurance companies. In those cases, I am responsible for the full payment.

→ I acknowledge I have provided the most accurate and current information to the best of my knowledge.

"RIGHT TO RECEIVE A GOOD FAITH ESTIMATE OF EXPECTED CHARGES" UNDER THE "NO SURPRISES ACT"

Beginning January 1, 2022, federal laws regulating client care have been updated to include the "No Surprises" Act. This Act requires health care practitioners to provide current and potential clients a "Good Faith Estimate" (GFE) on the cost of treatment.

There are a number of factors that make It challenging to provide an estimate on how long it will take for a client to complete therapeutic treatment, and much depends on the individual client and their goals in seeking therapy. Ultimately, as the client, it is your decision when to stop therapy.

Under the law, health care providers need to give patients who don't have insurance or who are not using insurance an estimate of the bill for medical items and services. You have the right to receive a "Good Faith Estimate" explaining how much your medical care will cost.

- Your health care provider will give you a Good Faith Estimate in writing at least 1 business day before your medical service.
- If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill.
- Make sure to save a copy or picture of your Good Faith Estimate.

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises

SIGNATURE _____ **DATE** _____

PATIENT MEDICAL HISTORY

Ear/Nose/Throat

- ❑ Hearing Loss
- ❑ Sinus Problems
- ❑ Sore Throat
- ❑ Other _____

Heart Issues

- ❑ Chest Pain
- ❑ Irregular Heartbeat
- ❑ Heart Attack
- ❑ Other _____

Urinary Issues

- ❑ Pain or Discomfort
- ❑ Blood in Urine
- ❑ Other _____

Skin Problems

- ❑ Excessive Dryness
- ❑ Other _____

Musculoskeletal Issues

- ❑ Muscle Aches
- ❑ Joint Pain
- ❑ Swollen Joints
- ❑ Other _____

Psychiatric Issues

- ❑ Depression
- ❑ Anxiety
- ❑ Other _____

Respiratory Issues

- ❑ Asthma
- ❑ Shortness of Breath
- ❑ Coughing
- ❑ Other _____

Gastrointestinal Issues

- ❑ Heartburn
- ❑ Belly Pain
- ❑ Diarrhea
- ❑ Other _____

Neurological Issues

- ❑ Numbness
- ❑ Weakness
- ❑ Headaches
- ❑ Paralysis
- ❑ Other _____

Miscellaneous

- ❑ High Blood Pressure
- ❑ Cancer _____
- ❑ Immune System Disorder
- ❑ Thyroid Disease
- ❑ Stroke
- ❑ Bleeding Disorder
- ❑ Hyperlipidemia
- ❑ Diabetes
- ❑ _____

Have you ever been diagnosed with any of the following eye conditions? *(check all that apply)*

☐ Glaucoma ☐ Wandering Eye ☐ Droopy Eyelid

☐ Cataract ☐ Detached Retina ☐ Other _____

PATIENT SURGICAL HISTORY

Procedure _____ Date_____

Procedure _____ Date_____

Procedure _____ Date_____

Procedure _____ Date_____

*List additional Procedures on the back of this page

ALLERGIES-PLEASE LIST

Food	Yes	No	_____
Medicine	Yes	No	_____
Other	Yes	No	_____

SMOKING HISTORY Never Current Former **ALCOHOL USE** # Drinks / Day _____ # / Week _____

FAMILY MEDICAL HISTORY (*Check all that apply)*

☐ Diabetes	Family Member _____
☐ High Blood Pressure	Family Member_____
☐ Cancer	Family Member _____
☐ Stroke	Family Member _____
☐ Bleeding Disorder	Family Member _____
☐ Asthma	Family Member _____
☐ Immune System Disorder	Family Member _____
☐ Other _____	Family Member _____

Is this appointment for a work-related injury? Yes No

Is this appointment for a Motor Vehicle Accident? Yes No

Please note - our office does not file claims to third party administrators. Accident related injuries will be managed through basic health insurance or private pay only.*

SIGNATURE _____ **DATE** _____

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Medication List

Please list medications below or bring your own copy of the medications you currently take.

PATIENT NAME: _____ **DATE:** _____

	MEDICATION	DOSE	FREQUENCY
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____
9.	_____	_____	_____
10.	_____	_____	_____
11.	_____	_____	_____
12.	_____	_____	_____
13.	_____	_____	_____
14.	_____	_____	_____
15.	_____	_____	_____

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PHOTOGRAPH CONSENT AND RELEASE

PATIENT NAME _____ **DATE** _____

MEDICAL RECORDS (please initial)

_____ I hereby acknowledge and understand that photographs will be taken of my face and parts of my face before and after surgery. I understand that these photographs will only be used for documentation in my medical record unless otherwise permitted. *See "Other Permissions."*

OTHER PERMISSIONS (please initial by the options to which you consent)

_____ **PHOTOGRAPHS**
I hereby give my consent for Donald A. Hollsten, M.D. and Jordan Hollsten, M.D. to use selected photographs on their website and professional social media platforms with basic details of my medical/surgical procedure to inform the public about specific plastic surgery methods and results. I understand that these photographs will be cropped and limited to specific parts of my face in order to protect patient confidentiality.

_____ Please initial here if you will allow our office to use the full image of your face without cropping.

_____ **VIDEOS**
I hereby give my consent for Donald A. Hollsten, M.D. and Jordan Hollsten, M.D. to use video documenting my medical procedure on their website and professional social media platforms with basic details of the procedure to inform the public about specific plastic surgery methods and results.

_____ **TESTIMONIALS**
I hereby give my consent for Donald A. Hollsten, M.D. and Jordan Hollsten, M.D. to use my personal written testimonial on their website and professional social media platforms. I understand that my testimonial will be quoted, followed by my first name and last initial and may include a brief descriptor of my medical/surgical procedure in order to provide better context.

By signing this form, I acknowledge my consent as initialed above, and I further recognize that this consent form will supersede any other photo consent forms with a date prior to the date written below. This consent may be revoked at any time by written request or by completion of a new form.

SIGNATURE _____ **DATE** _____

Ophthalmic Plastic and Reconstructive Surgery
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eyefacialplasticspecialists.com

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NOTICE OF PRIVACY PRACTICES

This practice uses and discloses health information about you for treatment, for payment of treatment, for administrative purposes, and for evaluation of quality of care you receive. This notice describes our privacy practices. You can request a copy of this notice at any time. For more information about this notice or our privacy practices and policies, please contact our privacy officer **Morgan Bowlin**.

OUR OBLIGATIONS We are required by law to: Maintain the privacy of protected health information, 2) Give you this notice of our legal duties and privacy practices regarding health information about you, 3) Follow the terms of our notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION You may revoke such permission at any time by writing your request to our practice Privacy Officer. ***For Treatment.*** We may use and disclose Health Information for your treatment and to provide you with treatment-related healthcare services. ***For Payment.*** We may use and disclose Health Information so that we, or others may bill and receive payment from you, and insurance company, or a third party for the treatment and services you received. ***For Health Care Operations***. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. ***Appointment Reminders, Treatment Alternatives, Health Related Benefits and Services, Individuals Involved in Your Care or Payment for Your Care.*** When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort. ***Research.*** Before we use or disclose Health Information for research, the project will go through a special approval process.

SPECIAL SITUATIONS*_As Required by Law.* We will disclose Health Information when required to do so by international, federal, state or local law. ***To Avert a Serious Threat to Health or Safety***. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat. ***Business Associates.*** We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. ***Organ and Tissue Donation.*** If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement. ***Military and Veterans.*** If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military. ***Workers' Compensation.*** We may release Health Information for workers' compensation or similar programs. ***Public Health Risks.*** We may disclose Health Information for public health activities. These activities include but are not limited to disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. ***Health Oversight Activities.*** We may disclose Health Information to a health oversight agency for activities authorized by law including audits, investigations, inspections, and licensure. ***Data Breach Notification Purposes.*** We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information. ***Lawsuits, Disputes and Law Enforcement.*** We may release Health Information if the information is: (1) in response to a court order, subpoena, warrant,
summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime. ***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 determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties. ***National Security and Intelligence Activities,***

Protective Services for the President and Others. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law. ***Inmates or Individuals in Custody.*** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official.

USES AND DISCLOSURES THAT YOU CAN OBJECT AND OPT ***Individuals Involved in Your Care or Payment for Your Care.*** Unless you object, we may disclose your Protected Health Information to any person you identify. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. ***Disaster Relief***. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES The following uses and disclosures of your Protected Health Information will be made only with your written authorization: (1) Uses and disclosures of Protected Health Information, (2) Disclosures that constitute a sale of your Protected Health Information.

YOUR RIGHTS You have the following rights regarding Health Information we have about you by requesting the information in writing to our ***Privacy Officer***; Right to Inspect and Copy and Right to an Electronic Copy of Electronic Medical Records; Right to Get Notice of a Breach; Right to Amend; Right to Request Restrictions; Out of Pocket Payments; Right to Request Confidential Communications; Right to a Paper Copy of This Notice.

CHANGES TO THIS NOTICE We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. The notice will contain the effective date on the first page, in the top right-hand corner.

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 Service. All complaints must be made in writing. **You will not be penalized for filing a complaint.** Contact information: Attn: Privacy Officer, 4114 Pond Hill Rd, Suite 100, San Antonio, TX 78231.

This Notice is effective on the date below. We may change our policies and this notice at any time and have those revised policies apply to all the protected health information we maintain.

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I have reviewed this office's notice of privacy practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

PRINTED NAME _____ **DATE** _____

SIGNATURE _____