

**STEPHEN J. LAQUIS MD, FACS**  
OPHTHALMIC FACIAL PLASTIC SURGERY SPECIALISTS, PA  
7331 College Parkway, Suite 200, Fort Myers, FL 33907  
860 111<sup>th</sup> Avenue North, Suite 1, Naples, FL 34108  
www.laquis.net

**Patient Registration Form**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Marital Status:  Single  Married  Divorce  Widowed Gender:  Male  Female

Local Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Northern Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Employer: \_\_\_\_\_

Cell Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Occupation: \_\_\_\_\_

Work Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Relationship: \_\_\_\_\_

Responsible Party:  Self  Other: \_\_\_\_\_

Referring Doctor: \_\_\_\_\_

Please check the one that applies to how you heard of us.

Yellow Pages  Newspaper  ER  Naples Daily News  Radio, which one? \_\_\_\_\_  Direct Mail

Web Site  Other Publication  Relative / Friend Name: \_\_\_\_\_  Other \_\_\_\_\_

Workers Compensation:  Yes  No Auto Accident:  Yes  No Date of Accident: \_\_\_\_\_

Claim #: \_\_\_\_\_ Contact Name: \_\_\_\_\_ PH: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ ID# \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ ID# \_\_\_\_\_

I, the undersigned authorize payment of medical benefits to Stephen J. Laquis, M.D., PA and Ophthalmic Facial Plastic Surgery Specialists, P.A. for any services furnished to me. I understand that I am financially responsible for any amount not covered by my contract. I also authorize the release to my insurance company or their agent information concerning health care advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

\_\_\_\_\_  
Patient, Parent or Guardian Signature Date

**Medicare Lifetime Signature on File: (Medicare Patients Only)**  
I request that payment of authorized Medicare Benefits be made on my behalf to Stephen J. Laquis, M.D., P.A & Ophthalmic Facial Plastic Surgery Specialists, P.A. for any services rendered. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information to determine these benefits payable for related services.

\_\_\_\_\_  
Patient Signature Date

MEDICAL HISTORY / REVIEW OF SYSTEMS (Page 1 of 2)

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_

Who is your primary care physician?	Name: _____	Ph: _____
Who is your cardiologist?	Name: _____	Ph: _____
Who is your pulmonologist?	Name: _____	Ph: _____
Who is your endocrinologist?	Name: _____	Ph: _____

REVIEW OF SYSTEMS: (Please check any that may apply to you.) **OR**  I do not have any problems

**CONSTITUTIONAL**

- \_\_\_\_ Recent fevers/sweats
- \_\_\_\_ Unexplained weight loss/gain
- \_\_\_\_ Unexplained fatigue/weakness

**EYE HISTORY**

- \_\_\_\_ Change in Vision
- \_\_\_\_ Double Vision
- \_\_\_\_ Dry Eyes
- \_\_\_\_ Baggy/Droopy Eyelids
- \_\_\_\_ Tearing
- \_\_\_\_ Eye Pain
- \_\_\_\_ Eye Injury/Trauma
- \_\_\_\_ Glaucoma
- \_\_\_\_ Retinal Disease
- \_\_\_\_ Cataract Surgery
- \_\_\_\_ Contact Lenses
- \_\_\_\_ Other \_\_\_\_\_

**ENT**

- \_\_\_\_ Hard of Hearing
- \_\_\_\_ Hay Fever/Allergies
- \_\_\_\_ Sinus Problems
- \_\_\_\_ Trouble Swallowing

**PULMONARY**

- \_\_\_\_ Asthma
- \_\_\_\_ COPD
- \_\_\_\_ Sleep Apnea CPAP? Yes or No
- \_\_\_\_ Oxygen Use

**MUSKULOSKELETAL**

- \_\_\_\_ Joint Replacement \_\_\_\_\_
- \_\_\_\_ Arthritis

**GASTROINTESTINAL**

- \_\_\_\_ Heartburn
- \_\_\_\_ Frequent Diarrhea
- \_\_\_\_ Frequent Vomiting

**SKIN**

- \_\_\_\_ Skin Cancer
- \_\_\_\_ Basal Cell
- \_\_\_\_ Squamous Cell
- \_\_\_\_ Melanoma

**NEUROLOGIC**

- \_\_\_\_ Headaches
- \_\_\_\_ Seizures
- \_\_\_\_ History of Stroke/TIA

**URINARY**

- \_\_\_\_ Urinary Frequency

**PSYCHIATRIC**

- \_\_\_\_ Anxiety
- \_\_\_\_ Depression

**ENDOCRINE**

- \_\_\_\_ Hypothyroid
- \_\_\_\_ Hyperthyroid
- \_\_\_\_ Diabetes
- Insulin Dependent / Oral (please circle)

**CARDIOVASCULAR**

- \_\_\_\_ Cardiac Stents
- \_\_\_\_ Heart Attack
- \_\_\_\_ Chest Pain
- \_\_\_\_ Atrial Fibrillation
- \_\_\_\_ Irregular Heartbeat
- \_\_\_\_ High Cholesterol
- \_\_\_\_ CHF
- \_\_\_\_ High Blood Pressure
- \_\_\_\_ Valve Replacement
- \_\_\_\_ Pacemaker
- \_\_\_\_ Defibrillator

**HEMATOLOGY/ONCOLOGY**

- \_\_\_\_ Blood disorders / clots
- \_\_\_\_ Anemia
- \_\_\_\_ Cancer Type: \_\_\_\_\_

**INFECTIONS / AUTOIMMUNE**

- \_\_\_\_ Hepatitis A, B, C (circle)
- \_\_\_\_ HIV
- \_\_\_\_ History of MRSA, When \_\_\_\_\_
- \_\_\_\_ Lupus
- \_\_\_\_ Sjogrens
- \_\_\_\_ Rheumatoid Arthritis

**FEMALES**

- \_\_\_\_ Pregnant? Yes or No

**TRANSPLANT**

- \_\_\_\_ What organ? \_\_\_\_\_

**SURGICAL HISTORY:** Please list all previous surgeries:

\_\_\_\_\_  
\_\_\_\_\_

Have you ever had any complications with anesthesia?  Yes  No

**FAMILY HISTORY:**

- Diabetes  Yes  No \_\_\_\_\_
- Arthritis  Yes  No \_\_\_\_\_
- Eye disease  Yes  No \_\_\_\_\_
- Cataracts  Yes  No \_\_\_\_\_
- Glaucoma  Yes  No \_\_\_\_\_
- Cancer  Yes  No \_\_\_\_\_

**SOCIAL HISTORY:**

- Do you smoke?  Current Smoker  Former Smoker  Never
- Do you drink alcohol?  Yes  No How many drinks per day? \_\_\_\_\_
- Do you use other recreational drugs?  Yes  No

Patient Signature / Representative Signature

Date

Reviewed by Provider: \_\_\_\_\_ Date: \_\_\_\_\_

**STEPHEN J. LAQUIS MD, FACS**  
 OPHTHALMIC FACIAL PLASTIC SURGERY SPECIALISTS, PA

PATIENT MEDICAL HISTORY FORM (Page 2 of 2)

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

**Do you have any allergies? Please include the reaction:**

- None  Latex \_\_\_\_\_  Iodine \_\_\_\_\_  Penicillin \_\_\_\_\_  Sulfa \_\_\_\_\_  Codeine \_\_\_\_\_
- Other \_\_\_\_\_

**Please list ALL MEDICATIONS you are currently taking, include SUPPLEMENTS and OVER THE COUNTER.**

Medication Name	Dose	Frequency

Are any of the medications that you are taking for the treatment of ADD/ADHD or Weight Loss? If YES list here:

\_\_\_\_\_

\_\_\_\_\_  
 Patient Signature / Representative Signature

\_\_\_\_\_  
 Date

**(OFFICE USE ONLY) Two Page History Reviewed:**

- Initial / Date \_\_\_\_\_  No Change  Updated: \_\_\_\_\_
- Initial / Date \_\_\_\_\_  No Change  Updated: \_\_\_\_\_
- Initial / Date \_\_\_\_\_  No Change  Updated: \_\_\_\_\_
- Initial / Date \_\_\_\_\_  No Change  Updated: \_\_\_\_\_
- Initial / Date \_\_\_\_\_  No Change  Updated: \_\_\_\_\_
- Initial / Date \_\_\_\_\_  No Change  Updated: \_\_\_\_\_
- Initial / Date \_\_\_\_\_  No Change  Updated: \_\_\_\_\_

Reviewed by Provider: \_\_\_\_\_ Date: \_\_\_\_\_

## **Patient Payment Policy & Agreement**

Thank you for choosing our practice. We are committed to the success of your medical treatment and care. Please understand that payment of your bills is part of this treatment and care. For your convenience we have answered a variety of commonly asked financial questions below. If you need further information about any of these policies, please ask to speak with our Financial or Insurance Specialists.

**Limitations of Practice:** Patient understands that Dr. Laquis specializes and limits his practice to ophthalmic plastic and orbital surgery. He does NOT provide general eye care or examinations or treat such conditions such as glaucoma or retinal problems, nor will he provide prescriptions for glasses.

**Patient Consent:** Patient hereby gives consent, if needed, for drawing blood samples for diagnosis or in the case of an accidental puncture or exposure of medical personnel during course of treatment either in the office or hospital. These tests may include AIDS testing.

**Insurance Claims Filing:** In all cases the patient is responsible for payment of their account. As a courtesy we will file a claim to the insurance carrier.

**Assignment and Release:** Patient hereby authorizes and assigns applicable insurance benefits to be paid directly to the physician. Patient is financially responsible for non-covered services. Patient authorizes release of information necessary to process insurance claims. Patient authorizes photographs to be restricted for medical, education or insurance purposes. Information released to other practitioners is in a good faith effort to improve medical care.

**Do I need a referral?** If you have an HMO plan with which we are contracted, you need a referral from your PRIMARY care physician. If we have not received an authorization by the time of your office visit, you will either need to re-schedule or your account will be considered a self pay (no insurance) and will need to be paid in full at the time of service. Again, the patient, not Dr. Stephen Laquis' office, is responsible for obtaining the referral in writing.

It is also the patient's responsibility to verify that Dr. Laquis is an In-Network Provider with their insurance company. Patients will be financially responsible for any Out-of-Network fees.

**Authorizations for Surgery:** Ultimately, the patient is responsible for verifying that all office visits and procedures, including surgeries, are authorized and approved by their insurance carrier. We will submit for approval for all pre-determinations, but the patient must verify with their carrier the authorization is on file. Failure to do so may result in the patient being responsible for any balance.

**Unpaid Balances:** All patient balances are due in full 30 days after insurance payment has been paid. If for any reason the patient cannot make acceptable payments, they must contact the office immediately for arrangements. Dr. Laquis reserves the right to refer all unpaid balances to either a collection agency, or in the case of a large balance, legal representation. Any fees associated with collections, including agency fees, court and attorney fees, will be added to the patient balance. After an account is placed with a collection agency, all further visits will be at the practice's discretion and on a cash only basis. Any account 60 days past due will begin to accrue at \$45 per month late fee.

**Credit Card Payments:** The fraud transactions from patients who dispute charge back for credit card amounts or dispute the payment will be prosecuted by the law and have to pay all legal and liability. In addition, a \$100 bank fee will be assessed for any attempt at charge backs with credit card payments.

**Please turn over and sign the back side of this form.**

If You Have:	You Are Responsible For:	Our Staff Will:
Medicare	<p>If you have regular Medicare, and have not met your deductible, payment is due at the time of service. Payment for any services not covered by Medicare is due at the time of service.</p> <p><u>If you have Regular Medicare as primary, but no secondary insurance: Payment of your 20% is due at the time of service</u></p>	<p>File the claim on your behalf, as well as any claims to your secondary insurance.</p> <p>Require that you sign an Advanced Beneficiary Notice (ABN)</p>
Medicare HMO	All applicable copays and deductibles are due at the time of service. You are responsible for obtaining a referral to be seen by our practice.	File the claim on your behalf, as well as any claims to your secondary insurance.
Medicare Replacement Plan	Verifying that our practice participates with your plan. If we do not participate, FULL financial responsibility is yours.	Attempt to obtain out-of-network benefits on your behalf.
Medicaid	Obtaining a referral and presenting your card with proof of identification at time of service.	Confirm your eligibility. If cannot be confirmed, self pay rates apply.
<b>Commercial Insurance</b>  Also known as indemnity, "regular" insurance, or "80% / 20% coverage"	<p>Payment of your financial responsibility portion of all office visits and procedures at the time of the office visit.</p> <p>Payment of your financial responsibility portion of your surgery is due at the time of your pre-operative appointment.</p> <p>Copays are ALWAYS to be paid upon check-out.</p>	<p>Call your insurance to determine copays, deductibles and coinsurance.</p> <p>File an insurance claim as a courtesy.</p>
<b>HMO &amp; PPO plans with which we are contracted.</b>	<p><u>If the services you receive are covered by the plan:</u> All applicable copays and deductibles are due at the time of service.</p> <p><u>If the services you receive are NOT covered by the plan:</u> Payment in full is required at the time of service.</p> <p>If no referral is on file, your insurance will not pay any portion of the service. You will then be responsible for 100% of the cost for the services rendered, or you must reschedule your appointment.</p>	<p>Call your insurance to determine copays, deductibles and non-covered services.</p> <p>File an insurance claim on your behalf.</p>
<b>HMO with which we are NOT contracted.</b>	Payment in full for office visit and procedures at the time of service.	Provide the necessary documentation for you to complete and file your own claim with the insurance company.
<b>Point of Service Plan or Out of Network PPO</b>	Payment of your financial responsibility portion of the deductible, copay and non-covered services are due at the time of service.	<p>Call your insurance to determine out of network benefits, copays, deductibles and non-covered services.</p> <p>File an insurance claim on your behalf.</p>
<b>Worker's Compensation</b>	<p><u>If we have verified the claim with your carrier:</u> No payment is necessary at the time of the visit.</p> <p><u>If we are not able to verify your claim:</u> Full payment is due at the time of service and may be refunded accordingly.</p>	Call your carrier ahead of time to verify the accident date, claim number, primary care physician, employer information and referral for procedures. We will need a copy of the incident report as well as the adjuster's name.
<b>Worker's Compensation (out of state)</b>	Payment in full is required at the time of service.	Provide the necessary documentation for you to complete and file your own claim with the insurance company.
<b>No Insurance</b>	Payment in full is required at the time of service.	<p>Work with you to settle your account.</p> <p>Please speak with our Financial Specialist if you need assistance.</p>
<b>Motor Vehicle Accident (MVA)</b>	Payment is required in full at the time of service. You may be granted a refund if the automobile insurance carrier pays our claim in full.	As a courtesy, file a claim with your carrier.

Patient's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**STEPHEN J. LAQUIS MD, FACS**  
OPHTHALMIC AND FACIAL PLASTIC SURGERY SPECIALISTS

**Notice of Privacy Practices**

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

At the office of Dr. Stephen Laquis, we will always keep your health information secure and confidential. We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. If you have any questions about this Notice, please contact our Privacy Officer. This medical practice collects health information about you and stores it in a chart or in an electronic health record. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. A law requires us to maintain your privacy, to give you this notice and to follow the terms of this notice. The law permits us to:

- Use or disclose your health information to those involved in your treatment. For example, your file may be reviewed by a physician specialist whom we involve in your care.
- Use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.
- Use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.
- Share your medical information with our business associates, such as a service that performs administrative services for us. We have a written contract with each business associate that requires them to protect your privacy.
- Use your information to contact you. For example, we may send newsletters or call and remind you of your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone. In an emergency, we may disclose your health information to a designated family member or another person authorized by you who is responsible for your care.
- Having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.
- Use your information for marketing purposes. Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans this practice participates in.
- We may use your information for marketing purposes. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization.
- We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.
- Release some or all of your health information when required by law.
- Disclose your health information to public health authorities. For example, reporting to the Food and Drug Administration problems with products and reactions to medications.
- Share your medical information if this practice is sold. Your information will become the property of the new owner.
- Use your information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.
- Use your health information as necessary to comply with workers' compensation laws. For example, to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.
- In the case of a breach of unsecured protected health information; we will notify you as required by law.

Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request. You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

You reserve the right to transfer copies of your health information to another practice. We will mail your files for you. You have the right to see and receive a copy of your health information with a few exceptions. You must give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies.

You have the right to request that you receive your health information in a specific way or at a specific location. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, treatment, payment, health care operations, notification and communication with family and specialized government functions.

You may request an amendment or change to your health information. You must give us your request in writing in order to make changes. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove or alter earlier documents, but will add new information.

Dr. Laquis reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. If we change any of the details of this notice, we will notify you of the changes in writing. You have the right to receive a copy of this notice by contacting Dr. Laquis' office at 7331 College Parkway, Suite 200, Fort Myers, Florida, 33907 or calling 239.947.4042.

You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, Washington DC, 20201. You will not be retaliated against for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our privacy officer at 239.947.4042.

I consent to the use or disclosure of my protected health information by Dr. Laquis for the purpose of the reasons stated above. I understand that diagnosis or treatment of me by Dr. Laquis may be conditioned upon my consent as evidenced by my signature on this document. I understand that I have the right to request a restriction as to how my protected health information is used or disclosed. Dr. Laquis is not required to agree to the restrictions that I may request. However, if Dr. Laquis agrees to a restriction that I request, the restriction is binding on Dr. Laquis' practice and on Dr. Laquis. I have the right to revoke this Consent, in writing at any time, except to the extent that Dr. Laquis' practice has taken action in reliance on the Consent.

My "Protected Health Information" means health information, including my demographic information collected from me and collected or received from another health care provider, a health plan, my employer or a health care clearinghouse. This protected information relates to my past, present, future physical or mental health condition and identifies me, or there is reasonable evidence which leads you to believe the information may identify me.

## Acknowledgement

I have read and understand and received a copy of the Notice of Privacy Practices for the office of Dr. Stephen Laquis.

\_\_\_\_\_  
Signed

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
If signing as a parent or guardian, please note the name of the patient

**Ophthalmic Plastic and Orbital Surgery**  
**Stephen J. Laquis, MD, FACS**

**Patient Authorization to Use or Disclose Protected Health Information For  
Purposes Other than Treatment, Payment or Healthcare Operations**

I, \_\_\_\_\_, understand Ophthalmic Facial Plastic Surgery Specialists, P.A. is  
(Print Name)

authorized by me to use or disclose my protected health information for treatment, payment or health care operations only. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information and the recipient(s) of that information. I specifically authorize any current employee or owner at Ophthalmic Facial Plastic Surgery Specialists, P.A. or any other individual listed below to disclose my protected health information as described on this form to the recipients listed below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization.

I understand, and authorize my health care provider to use my name, address and phone number; the name of my scheduled treating physician; and the time and place of my scheduled appointment(s), for the limited purpose of contacting me to notify me of a pending appointment or other healthcare related communication. I also authorize my healthcare provider to disclose to third parties who answer my phone limited protected health information regarding pending appointments and to leave a reminder message on my voice mail system or answering machine.

Do you give us permission to discuss your medical and financial information with family members and/or friends?

- Yes  
 No

If yes, please list the friends/ family members that you would like to authorize us to speak to:

Name	Relationship	Phone Number
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Patient's Signature \_\_\_\_\_ Date: \_\_\_\_\_