STEPHEN J. LAQUIS MD, FACS
OPHTHALMIC FACIAL PLASTIC SURGERY SPECIALISTS, PA
7331 College Parkway, Suite 200, Fort Myers, FL 33907
860 111th 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**

STEPHEN J. LAQUIS MD, FACS

OPHTHALMIC FACIAL PLASTIC SURGERY SPECIALISTS, PA

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 <u>SUPPLEMENTS, OVER THE COUNTER or DIETARY</u>

Medication Name	Dose	Frequency	Route of Administration (circle one)
			oral / injection / topical / suppository
			oral / injection / topical / suppository
			oral / injection / topical / suppository
			oral / injection / topical / suppository
			oral / injection / topical / suppository
			oral / injection / topical / suppository
			oral / injection / topical / suppository
			oral / injection / topical / suppository
			oral / injection / topical / suppository
			oral / injection / topical / suppository
			oral / injection / topical / suppository
			oral / injection / topical / suppository
			oral / injection / topical / suppository

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
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
Initial / Date____________________ ☐ No Change ☐ Updated
Initial / Date____________________ ☐ No Change ☐ Updated

Reviewed by Provider: ________________**Date:**_______

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

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 you 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 30% additional 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	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. If you have Regular Medicare as primary, but no secondary insurance: Payment of your 20% is due at the time of service	File the claim on your behalf, as well as any claims to your secondary insurance. Require that you sign an Advanced Beneficiary Notice (ABN)
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.
Commercial Insurance Also known as indemnity, "regular" insurance, or "80% / 20% coverage"	Payment of your financial responsibility portion of all office visits and procedures at the time of the office visit. Payment of your financial responsibility portion of your surgery is due at the time of your pre-operative appointment. Copays are ALWAYS to be paid upon check-out.	Call your insurance to determine copays, deductibles and coinsurance. File an insurance claim as a courtesy.
HMO & PPO plans with which we are contracted.	If the services you receive are covered by the plan: All applicable copays and deductibles are due at the time of service. If the services you receive are NOT covered by the plan: Payment in full is required at the time of service. 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.	Call your insurance to determine copays, deductibles and non-covered services. File an insurance claim on your behalf.
HMO with which we are NOT contracted.	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.
Point of Service Plan or Out of Network PPO	Payment of your financial responsibility portion of the deductible, copay and non-covered services are due at the time of service.	Call your insurance to determine out of network benefits, copays, deductibles and non-covered services. File an insurance claim on your behalf.
Worker's Compensation	If we have verified the claim with your carrier: No payment is necessary at the time of the visit. If we are not able to verify your claim: Full payment is due at the time of service and may be refunded accordingly.	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.
Worker's Compensation (out of state)	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.
No Insurance	Payment in full is required at the time of service.	Work with you to settle your account. Please speak with our Financial Specialist if you need assistance.
Motor Vehicle Accident (MVA)	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.

Revised 09.19.13

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
Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number

Patient's Signature ______________________________________ Date: ____________

9/6/2011