SILKISS
EYE
SURGERY

RONA Z. SILKISS, MD, FACS

Diplomates, American Board of Ophthalmology

Ophthalmic Plastic, Reconstructive & Orbital Surgery

Cosmetic Eyelid Surgery

TEL 510.763.0881
FAX 510.763.0907
www.eyework.com

400 29th Street
Suite 315
Oakland, CA 94609

1820 San Miguel Drive
Walnut Creek, CA 94596

686 Mowry Avenue
Fremont, CA 94536

100 Tamal Plaza
SUite 120
Corte Madera, CA 94925

15051 Hesperian Boulevard
Suite D
San Leandro, CA 94578

1805 EL Camino Real
Suite 100
Palo Alto, CA 94306

711 Van Ness Avenue
Suite 340
San Francisco, CA 94102

Cosmetic Consult Questionnaire

Name: _____ Date: _____

How did you hear about us?

_____

What physical areas are you considering for cosmetic treatment?

☐ Face ☐ Eyes/Eyelids ☐ Eyebrow/Forehead
☐ Lips ☐ Cheeks/Midface ☐ Other: _____

What characteristic of the area would you like to improve?

☐ Wrinkles ☐ Volume ☐ Asymmetry
☐ Too Small ☐ Too Prominent ☐ More Youthful
☐ Fat ☐ Color/Pigmentation

Have you had previous cosmetic treatment?

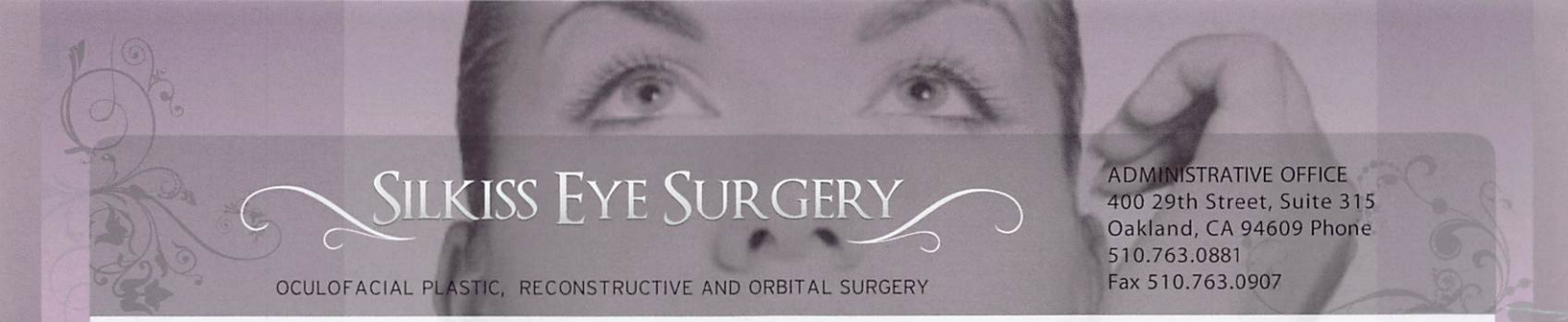
☐ Non-Surgical (Botox, fillers, laser, etc.): _____
☐ Plastic Surgery: _____

What is your ideal time frame for treatment?

☐ Soon ☐ 1-3 months ☐ Other: _____

Is there an upcoming occasion or date you are working with? _____

If yes: _____



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OCULOFACIAL PLASTIC, RECONSTRUCTIVE AND ORBITAL SURGERY

ADMINISTRATIVE OFFICE
400 29th Street, Suite 315
Oakland, CA 94609 Phone
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Fax 510.763.0907

Date_____

Name _____ Sex:

Address _____
Street Apt # City State Zip

Birth date _____/_____/_____ Age_____ Soc. Sec #_____/_____/_____

Phone: Cell (____)_____ Home (____) _____ Work (____) _____

E-Mail Address_____

Primary Physician_____
Name City Phone Fax

How did you hear about Silkiss Eye Surgery? _____

Referring Doctor _____
Name City Phone Fax

Emergency Contact: _____
Name Relationship Phone

Preferred Pharmacy _____ Address_____ Phone _____

HEALTHCARE QUESTIONNAIRE

Past Medical History:

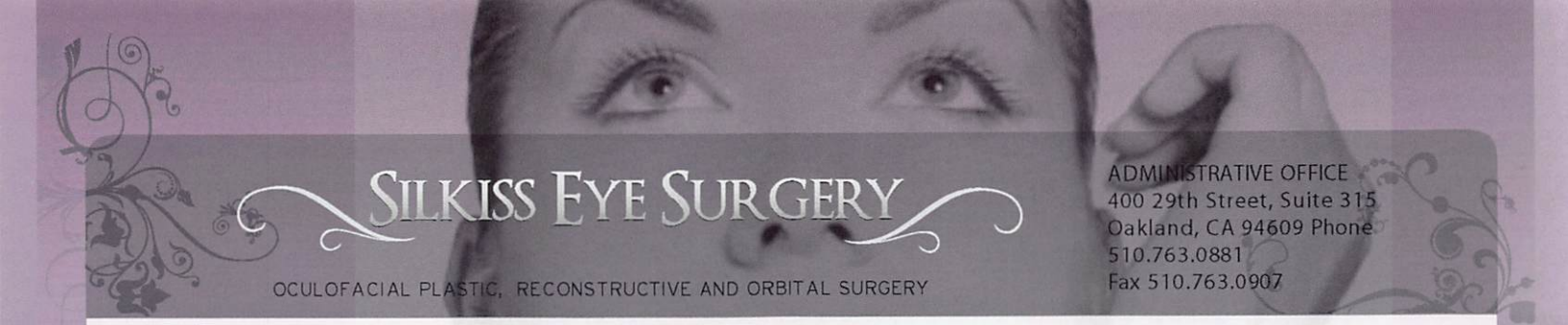
Asthma/COPD
Cancer (Please Specify)_____
Depression
Diabetes
Heart Disease (Specify) _____
Other: _____
_____

High Blood Pressure
High Cholesterol
Stroke
Thyroid Disease (Please Specify) _____

Please list your medications:

Name	Dose	Frequency	Route

Allergies: _____



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Date_____

Name _____DOB:_____/_____/_____

Social History

Do you currently smoke or use tobacco products? _____ If yes, have you considered quitting? _____

Do you have a history of smoking/tobacco use? _____ If yes, when did you quit? _____

Do you drink alcohol? _____

If yes: How often do you have a drink containing alcohol? _____

How many standard drinks containing alcohol do you have on a typical day? _____

How often do you have 6 or more drinks on one occasion? _____

Demographics

What is your race?

- Asian or Asian American
- African or African American
- Caucasian or European American
- Native American or Native Alaskan
- Native Hawaiian or other Pacific Islander

What is your ethnicity?

- Hispanic/Latino
- Non-Hispanic/Latino

Other: _____

Health Screening

1. Did you receive an influenza vaccination this year? _____
   If yes, please list date and provider: _____
2. Have you ever received a pneumococcal vaccination? _____
   If yes, please list date and provider: _____
3. Are you being treated for glaucoma? _____
   If yes, please list provider: _____
4. Do you have diabetes? _____
   If yes, have you received your yearly diabetic eye exam? Date_____Provider_____
   If yes, have you undergone HbA1c testing?_____ Date_____Location_____Result_____
5. Are you being treated for macular degeneration? _____
   If yes, please list provider: _____
6. If you have macular degeneration, are you currently taking eye vitamins or antioxidant supplements? _____
7. If you are over 65, do you worry about falling?_____
8. If you are female, did you receive your mammogram this year? _____

SILKISS EYE SURGERY
400 29th STREET, SUITE #315
OAKLAND, CA 94609-3548

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I hereby authorize Silkiss Eye Surgery to release records to my medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, or employer, any information regarding my condition. A photocopy of this authorization shall be considered as effective and validated as the original.

Patient or guardian signature _____ Date _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN

I hereby authorize payment to be made directly to Silkiss Eye Surgery for the medical and/or surgical benefits provided to me. If my insurance company should deny payment for any service received, I will be responsible for payment.

Patient or guardian signature _____ Date _____

MANAGED CARE AGREEMENT

As a member of a managed care plan, I understand that, in most cases, I am responsible for obtaining authorizations from my primary care physician. I also understand that if I do not obtain the proper authorization I will be responsible for the cost of my visit. In signing this agreement, I acknowledge my financial obligation and agree to work with Silkiss Eye Surgery to obtain insurance authorization for each visit.

Patient or guardian signature _____ Date _____

HIPAA ACKNOWLEDGMENT

I acknowledge that I have read the HIPAA Notice of Privacy Practices.

Patient or guardian signature _____ Date _____

CANCELLATION POLICY

A $100.00 cancellation fee may be charged for a no show or late cancellation (within 24 hours)

Patient or guardian signature _____ Date _____

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SAN FRANCISCO, CA 94102

Telehealth Medicine Appointment

Silkiss Eye Surgery offers Telehealth Medicine appointments. We also send appointment reminders via text messaging. Though there may be personal information in the text messages, no medical information is included.

Please let us know your preference:

☐ Yes, I authorize Silkiss Eye Surgery to proceed with Telemedicine appointments.

☐ No, I do not wish to be contacted for Telemedicine appointments.

☐ Yes, I authorize Silkiss Eye Surgery to send me text message reminders.

Please provide a mobile phone number for text messages:

_____

☐ No, I do not wish to be contacted via text messaging.

Name: _____

Signature: _____

Date: _____

Silkiss Eye Surgery
400 29TH Street, Suite #315
Oakland, CA 94609-3584

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLASED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or healthcare operations (TPO) and for other purposes that are permitted or required by law. It also describes your right to access and control your protected health information. "Protected health information" Is information about you, including demographic information, that may identity you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected health Information. Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to the home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operation: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities for addition, we may use a sigh in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use disclosing your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirement: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
The following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information complied in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information not to be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you agree to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 14, 2003

We are required by law to maintain the privacy of and provide. Individuals with this notice of our legal duties and privacy practices with respect to protected health information, if you have any objections to this form, please ask to speak with our HIPAA compliance officer in person or phone our Main Phone Number.