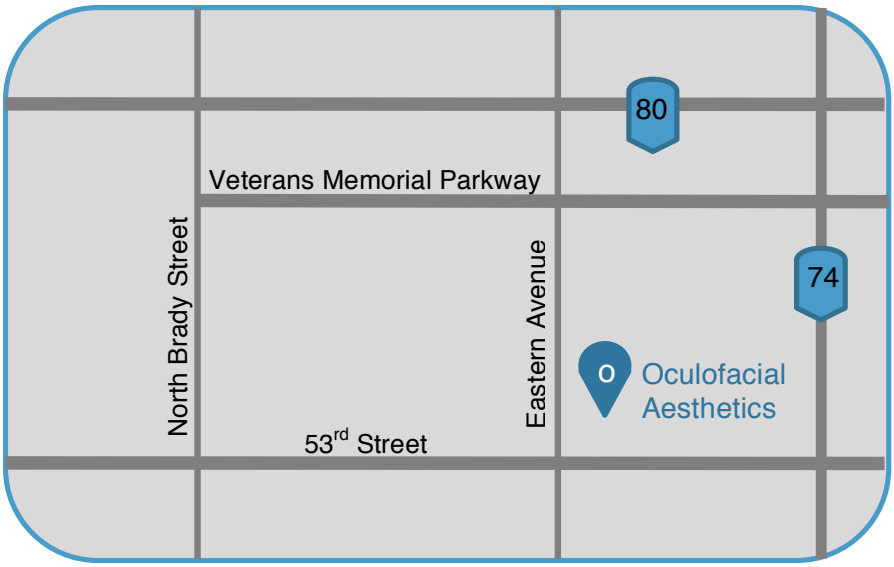
OCULOFACIAL
AESTHETICS PLC

Thank you for choosing Oculofacial Aesthetics, PLC. Your doctor referred you to us for a medical consultation. In this scenario, the care we will provide typically falls under your medical benefits. Because everyone's insurance is unique, we will request a prior authorization from your insurance company before you have a procedure with us.

At Oculofacial Aesthetics, we also provide cosmetic procedures. These procedures are not covered by insurance. Our office will let you know if your procedure is considered cosmetic prior to you deciding to proceeded.

Our office is conveniently located on Eastern Avenue, accessible via 53rd Street, from either US 61 or I-74. We are near Waterford Center and the Genesis Physical Therapy and Sports Medicine office.



Please remember to bring the following items to your appointment:

- Driver's license
- Insurance card
- Your insurance copay
- Your new patient packet containing your health history questionnaire

Your appointment is scheduled for:

Date	
Time	

We look forward to seeing you at your upcoming visit.

5335 Eastern Ave Suite C • Davenport, Iowa 52807 • P: 563-213-5080 • F: 563-355-5070
www.OFAeyes.com

This notice describes how medical information about you may be used and disclosed, and how you can gain access to this information. Please review it carefully.

Protected health information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services.

Our practice is required to follow specific rules on maintaining the confidentiality of your PHI, using your information, and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules and use and disclose your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

Your Rights Under The Privacy Rule

Following is a statement of your rights, under the Privacy Rule, in reference to your PHI. Please feel free to discuss any questions with our staff.

You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices - We are required to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment. The Notice will also be posted in a conspicuous location within the practice, and if such is maintained by the practice, on it's web site.

You have the right to authorize other use and disclosure - This means you have the right to authorize any use or disclosure of PHI that is not specified within this notice. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or our practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to request an alternative means of confidential communication – This means you have the right to ask us to contact you about medical matters using an alternative method (i.e., email, telephone), and to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, using a form provided by our practice, how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.

You have the right to inspect and copy your PHI - This means you may inspect, and obtain a copy of your complete health record. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable fee for paper or electronic copies as established by professional, state, or federal guidelines.

You have the right to request a restriction of your PHI - This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

You may have the right to request an amendment to your protected health information - This means you may request an amendment of your PHI for as long as we maintain this information. In certain cases, we may deny your request.

You have the right to request a disclosure accountability - This means that you may request a listing of disclosures that we have made, of your PHI, to entities or persons outside of our office.

You have the right to receive a privacy breach notice - You have the right to receive written notification if the practice discovers a breach of your unsecured PHI, and determines through a risk assessment that notification is required.

If you have questions regarding your privacy rights, please feel free to contact our Privacy Manager. Contact information is provided on the following page under Privacy Complaints.

How We May Use or Disclose Protected Health Information

Following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.

Treatment - We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other Healthcare Providers who may be involved in your care and treatment.

Special Notices - We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests and to provide information that describes or recommends treatment alternatives regarding your care. Also, we may contact you to provide information about health-related benefits and services offered by our office, for fund-raising activities, or with respect to a group health plan, to disclose information to the health plan sponsor. You will have the right to opt out of such special notices, and each such notice will include instructions for opting out.

Payment - Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you such as, making a determination of eligibility or coverage for insurance benefits.

Healthcare Operations - We may use or disclose, as needed, your PHI in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, auditing functions and patient safety activities.

Health Information Organization - The practice may elect to use a health information organization, or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

To Others Involved in Your Healthcare - Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person, that you identify, your PHI that directly relates to that person's involvement in your healthcare. 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. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your general condition or death. If you are not present or able to agree or object to the use or disclosure of the PHI, then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed.

Other Permitted and Required Uses and Disclosures - We are also permitted to use or disclose your PHI without your written authorization for the following purposes: as required by law; for public health activities; health oversight activities; in cases of abuse or neglect; to comply with Food and Drug Administration requirements; research purposes; legal proceedings; law enforcement purposes; coroners; funeral directors; organ donation; criminal activity; military activity; national security; worker's compensation; when an inmate in a correctional facility; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

Privacy Complaints

You have the right to complain to us, or directly to the Secretary of the Department 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 the Privacy Manager at:

_____

We will not retaliate against you for filing a complaint.

Effective Date February 11, 2016 Publication Date February 11, 2016

OCULOFACIAL
AESTHETICS PLC

Statement of Patient Financial Responsibility

We are glad you have chosen Oculofacial Aesthetics, PLC as a partner in your health care. We want to share our financial policy with you, because it outlines both patient financial responsibilities, as well as our office's financial responsibilities. We hope our policy helps avoid any misunderstanding or disagreements concerning payment for professional services.

- We require your copayment at the time of service. You are financially responsible for any amounts not covered by your insurer. You are responsible to pay any deductible, copayment or any portion of the charges specified in your contract with your insurance carrier. If your insurer denies any part of your claim, you are responsible for your balance, in full.
- We participate with numerous insurance companies. For patients who are beneficiaries of one of these insurance companies, our office will submit a claim for services rendered. All necessary insurance information, including special forms, must be completed by the patient prior to leaving the office.
- If a patient has insurance in which we do not participate, we are happy to file the claim upon request; however, payment in full is expected at the time of service.
- It is the patient's responsibility to ensure any required referrals for treatment are provided to the practice prior to the visit. Visits may be rescheduled or the patient may be financially responsible due to lack of the referral.
- It is the patient's responsibility to provide us with current insurance information and bring their insurance card to each visit.
- We are happy to help with insurance questions relating to how a claim was filed, or regarding any additional information the payer might need to process the claim. Specific coverage issues, however, can only be addressed by the insurance company member services department. (The telephone number is printed on the insurance card.)

We firmly believe a good physician-patient relationship is based on understanding and good communication. Questions about financial arrangements should be directed to the medical practice. We are here to help.

I have read the above policy regarding my financial responsibility to Oculofacial Aesthetics, PLC for providing medical services to me or the below named patient. I certify the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Oculofacial Aesthetics, PLC, the full and entire amount of the bill incurred by me or the below named patient; or, if applicable any amount due after payment has been made by my insurance carrier. I further authorize the release of any information necessary to process any claim with my insurance carrier.

Guarantor name (Please Print)	Guarantor signature	Date

5335 Eastern Ave Suite C • Davenport, Iowa 52807 • P: 563-213-5080 • F: 563-355-5070
www.OFAeyes.com

Authorization to use SureScripts, Inc.	
Patient name: _____ DOB: _____	Date:___/____/_____

1. I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form: in accordance with Iowa State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:
2. Oculofacial Aesthetics, PLC uses SureScripts, Inc., a prescription system that allows prescriptions and related information to be exchanged between my providers and the pharmacy. The information sent between these systems may include details of any and all prescription drugs I am currently taking and/or have taken in the past. This information will be utilized to Oculofacial Aesthetics, PLC.
3. This authorization may include disclosure of prescription information related to alcohol and drug abuse, mental health treatment, and/or confidential HIV related information by SureScripts, Inc. to Oculofacial Aesthetics, PLC.
4. I have the right to revoke this authorization at any time by writing to Oculofacial Aesthetics, PLC. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
5. Signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
6. Information disclosed under this authorization might be re-disclosed by the recipient, and this re-disclosure may no longer be protected by state or federal law.
7. This authorization expires one year from the date of my signature below.
8. THIS AUTHORIZATION DOES NOT AUTHORIZE OCULOFACIAL AESTHETICS, PLC TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THOSE PERMITTED UNDER APPLICABLE LAW.

Signature of patient or representative authorized by law: _____

Relationship to patient: _____

Interpreter, if utilized: _____

Witness: _____

Date: _____

OCULOFACIAL AESTHETICS PLC

Patient Name: _____ Date of Birth: _____

Eyelid Questionnaire

Please circle one response for each question:

Do you feel a sensation of heaviness of the upper eyelid?	Never	Sometimes	Frequently	Daily
Do you experience an ache or fatigue of your eyebrows or forehead later in the day?	Never	Sometimes	Frequently	Daily
Do other people tell you that your eyes or eyelids look tired and droopy?	Never	Sometimes	Frequently	Daily
Do you notice droopy/heavy eyelids when you view yourself in the mirror or in photos?	Never	Sometimes	Frequently	Daily
Do you notice decreased upper vision that improves when you raise your eyebrows, tilt your head back or lift your eyelids with your fingers?	Never	Sometimes	Frequently	Daily
Do you have difficulty with the following activities?				
1. Seeing elevated traffic or street signs while driving?	Never	Sometimes	Frequently	Daily
2. Working at a computer or reading without raising your eyebrows?	Never	Sometimes	Frequently	Daily
3. Applying eye shadow or mascara due to excess eyelid skin?	Never	Sometimes	Frequently	Daily
4. Performing routine activities, work or hobbies without raising your eyebrows?	Never	Sometimes	Frequently	Daily
On a scale of 0 to 10, please rate your pain, with zero being no pain and 10 be the worst level of pain.	_____			

By signing below, I certify the above information is complete and correct to the best of my knowledge

Patient Name: _____ Date: _____

5335 Eastern Ave Suite C • Davenport, Iowa 52807 • P: 563-213-5080 • F: 563-355-5070
www.OFAeyes.com

OCULOFACIAL AESTHETICS

Patient Intake Questionnaire			
First name:		**Marital status:**	
Last name:		**Employer/occupation:**	
Middle name:		**If retired, previous occupation:**	
Preferred name:		**Home phone:**	
Former last name:		**Mobile phone:**	
Date of birth:		**Work phone:**	
Social security number:		**Email:**	
Address:		**Contact preference (circle):**	Home phone/Cell phone/ Work phone /email
City:		**Patient care summary (circle):**	Please print/ I will access on my portal
State:		**Preferred pharmacy:**	
Zip code:		**Primary care provider:**	
Driver's license #:		**Cardiologist (if any):**	
Gender:		**Emergency contact name and number:**	
		Emergency contact relationship:	

Primary Insurance Information

Policy holder:	
Relationship to policy holder:	
Guarantor (if policy holder is not patient):	
Guarantor address (if different than above):	
Insurance card number:	

Secondary Insurance Information

Policy holder:	
Relationship to policy holder:	
Guarantor (if policy holder is not patient):	
Insurance card number:	

OCULOFACIAL AESTHETICS

General Health History Questionnaire	
Patient name: _____ DOB: _____	Date:_____

Please tell us about your current or past health conditions by checking the boxes					
Please answer all questions	Y	N	Please answer all questions	Y	N
Cardiovascular			**Endocrine/Rheumatologic Continued**		
High blood pressure			Scleroderma		
Taking medication for high blood pressure			Rheumatoid arthritis		
Coronary Artery Disease			**Musculoskeletal**		
Angina/chest pain			Arthritis		
History of heart attack (MI)			Chronic back pain		
Congestive heart failure			Chronic neck pain		
Heart valve disease/murmur			Restless leg syndrome		
Irregular heart rhythm			Scoliosis		
Have pacemaker			Joint replacement, knee (R/L)		
Blocked circulation to extremities			Joint replacement, hip (R/L)		
Blocked carotid arteries			**Psychological**		
Clotting Disorders			Dementia		
Take aspirin daily			Alzheimer disease		
Take NSAIDs (ibuprofen/naproxen)			Bipolar disorder		
Take blood thinners			History of stroke		
Respiratory			Seizure disorder		
Asthma			Fibromyalgia		
Emphysema/COPD			**Women only**		
Chronic bronchitis			Pregnant		
Recent respiratory infection			Breast-feeding		
Pneumonia			Hysterectomy		
Tuberculosis			**Other**		
Obstructive sleep apnea			Slow or poor wound healing		
Use CPAP machine at night			Cold sores, herpes, shingles		
Regular oxygen use			Skin cancer/type		
Kidney/Bladder			Other cancer, type		
Renal insufficiency			Psoriasis, eczema, other skin disorder		
Kidney failure requiring dialysis			MRSA, VRE, other infection		
Missing one kidney/kidney transplant/extra kidney			Hepatitis, check Y/N and circle type: A / B / C		
Incontinent of urine			HIV		
Frequent infections			Problems undergoing general anesthesia		
Endocrine/Rheumatologic Continued			Problems undergoing conscious sedation		
Diabetes controlled with insulin			Problems undergoing local anesthesia		
Diabetes controlled with oral meds			Have you had two or more falls this year?		
Diabetes controlled with diet			Have you talked with your primary doctor about falls?		
Lupus			Has your doctor recommended weight loss?		
Thyroid Disease			Are you working with your doctor on weight loss?		
			If needed, would you like us to refer you to your primary doctor for managing your weight?		

General Health History Questionnaire	
Patient name: _____ DOB: _____	Date:_____

In your own words, please tell us what brings you to see us today
How would you rate your pain today, if any, on a scale of 0 to 10, with 10 being the worst possible pain: _____

Please tell us about your allergies or sensitivities to medications			
Allergy/Sensitivity	**Reaction**	**Severity (Mild/Moderate/Severe)**	**Date you first developed allergy**

Please tell us about your family's health history by checking the boxes			
	Diabetes	**Thyroid problems**	**High blood pressure**
Father			
Mother			
Brother/Sister			
Brother/Sister			

Please tell us about your social habits, height and weight by completing the table				
Smoking	Yes	No	Current amount, how many years:	
Alcohol	Yes	No	Current amount	
Drug use	Yes	No	Drug, frequency:	
Height			Weight	

Please tell us about any surgeries you have had		
Surgery site	**Year of surgery**	**Surgeon or facility**

Please circle any of the following symptoms if they are new	
General	diarrhea / vomiting / weight loss (unintentional) / fever
Ears	difficulty hearing / deafness
Neurologic	numbness / seizures / dizziness, weak limbs (paresis)
Cardiovascular	chest pain / palpitations
Musculoskeletal	muscle pains / joint pains / back pain
Respiratory	cough / wheezing / sleep apnea
Allergy/Immunologic	runny nose / sinus pressure / itching
Endocrine	prominent eyes / muscle weakness
Blood/hematologic	easy bleeding / easy bruising / frequent nose bleeds
Eye	Discomfort / itching / double vision

General Health History Questionnaire	
Patient name: _____ DOB: _____	Date:_____

Please tell us about your immunizations by completing the table			
Have you had a pneumonia (pneumovax) vaccine?	Yes	No	If yes, when?
Have you had an influenza vaccine?	Yes	No	If yes, when?

List below all medications, supplements, vitamins, minerals and herbal supplements you take		
Medication name	Dose	Frequency (daily, twice daily, etc.)