MARCUS J. KO, M.D., F.A.C.S.
5435 Reno Corporate Drive, Suite 100
Reno, NV 89511

Dear Patient,

I would like to welcome you to our practice. Dr. Ko is Northern Nevada's only fellowship trained Oculoplastic (Eyelid Plastic) Surgery specialist. We are pleased that you and your referring doctor have selected our office to discuss your specific oculoplastic concerns and we will strive to achieve the discussed mutual goals of patient and surgeon.

Please **complete** the enclosed patient registration forms and bring these, along with your insurance cards and photo identification to your appointment **15 minutes prior to your scheduled appointment time to process your check in.**

If your family will be helping you make decisions regarding your surgery, please bring them to your initial consultation to ensure that **all questions are answered *prior* to your surgery**. Surgeries are scheduled one after the other and therefore, your doctor will not have the time **to provide** another consultation to you or your family at the time of surgery.

Insurance:

Please call our office to ensure we are contracted with your insurance plan b*efore* your appointment, especially if you have changed your insurance plan since making your appointment. If contracted, we will do our best to obtain any prior authorizations required by your insurance company, however it is **ultimately your responsibility to ensure you** know your specific copays and deductible amounts, which will be **collected at the time services are rendered** and to obtain any required prior authorizations or PCP referrals if applicable. If you have any questions regarding these issues, please ask us **prior** to your appointment date. Please note, we are currently not contracted with Tricare, Humana, most Medicaid plans and most Blue shield of CA plans.

Important Policies:

We work very hard to stay on schedule, but occasionally emergencies arise so we do apologize if you are delayed. Please notify our office at least 24 hours in advance if you cannot keep your scheduled appointment so that we may be able to accommodate others on our waiting list. **Should you no call, no show for your office appointment or late cancel, you will be charged $75.00 (office visit) or $200.00 (surgery) to reschedule your appointment.**

Due to an unprecedented increase in the number of disruptions during examinations from cell phones and unsupervised children, we must request that all cell phones be turned off while in the office, and unless the child is the patient, please make childcare arrangements prior to your consultation.
Please also refrain from wearing eye make up to your appointment.

HIPAA and patient portal:

The **HIPAA 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. The full HIPAA notice of private practices is displayed in our office and a copy will be provided to you at your request.

Due to increased government regulations, we are now required to utilize electronic medical records and to provide you with access to your patient portal, called Patient Fusion where you may look up your basic medical information. If you provide us with your email address, you will automatically be invited to our Patient Fusion Portal. If you would like to be removed from our patient portal, please notify our office.
You will also be sent appointment reminders via text messaging and email. Text messaging fees may apply by your phone carrier. If you would like to opt out of these reminders, please notify our office immediately.

Thank you and we look forward to meeting you.

Patient Name: _____ **Date:** _____

Please list reason for today's visit and any symptoms you are currently experiencing

Please select any ALERTS that apply	
Defibrillator or Pacemaker	
Premedication Prior to Surgery	
Rapid Heart Beat with Epinephrine	
Pregnant	
Steroid Responder	

Do you Smoke? ❑ Yes ❑ No If yes, how many cigs/day _____
Have you had your flu vaccine this year? ❑ Yes ❑ No If not, why? _____
If > 50 years old, have you had your Herpes Zoster Vaccine? ❑ Yes ❑ No If not, why? _____
Have you had a Tetanus TD or Tdap Vaccine within the last 10 years? ❑ Yes ❑ No If not, why? _____
Have you had your full COVID vaccination(s)/boosters? ❑ Yes ❑ No If not, why? _____

If >65 years old, have you had 2 or more unintentional, spontaneous falls in the last 12 months? ❑ Yes ❑ No
(Do not answer yes if the fall was due to sudden paralysis, epileptic seizures or being hit by an object.)
Approx. how many days in the last year have you had more than 4 drinks/day (women) or 5 drinks/day (men)? _____ drinks/day
If you're diabetic, have you have a dilated eye exam or exam with retinal photos in the last 1 year? ❑ Yes ❑ No
If yes, did the eye exam show any retinopathy? ❑ Yes ❑ No

Family History

Please list any family members and significant medical conditions: _____
_____

Past Surgeries

Please list ALL your previous surgeries:
_____
_____
_____

Past Medical History

Please check all that apply					
❑	Anxiety	❑	COPD	❑	Hypothyroidism
❑	Arthritis	❑	Coronary Artery Disease	❑	Hyperthyroidism
❑	Asthma	❑	Hearing Loss	❑	Skin : Basal Cell Carcinoma Squamous Cell Carcinoma Melanoma Cancer Locations/dates:
❑	Atrial Fibrillation (Irreg Heart beat)	❑	Hepatitis – Type:		
❑	Autoimmune Disorders (Please specify)	❑	High blood pressure		
❑	Cancers (Please specify):	❑	High Cholesterol		
❑	Diabetes	❑	HIV/AIDS		

Please list any others: _____
_____
_____

Ocular History

Please check all that apply								
❑	Dry Eyes				❑	Cataract Surgery	Right	Left	Both
❑	Blindness	Right	Left	Both	❑	Eye Lid Surgeries	Right	Left	Both
❑	Glaucoma	Right	Left	Both					
❑	Graves' Thyroid Eye Disease				❑	Retinal Conditions	Right	Left	Both

Please list any others: _____
_____

Do you have hardware in your body? ❑ Yes ❑ No If yes, where? _____

Are you taking any blood thinners? ❑ Yes ❑ No

Do you have a history of MRSA? ❑ Yes ❑ No

Are or will you be taking any semaglutides*? E.g. Ozempic or Mounjaro* ❑ Yes ❑ No

Allergies

Have you had any drug allergies?

❑ Yes ❑ No

Please list allergy, reaction and severity of allergy: *e.g. Penicillin, sulfa, codeine, iodine, latex, adhesives, lidocaine etc. - Severe Rash*

_____

_____

_____

Medications

Please Include All Prescription, Over The Counter Medications, and Herbal Supplements or provide a separate list.

Medication Name	Dosage	Frequency

Patient Signature: _____ **Date:** _____

PATIENT INFORMATION

Last Name	**First Name**		**MI**
Mailing Address	**City**	**State**	**Zip**
Home Phone **Cell Phone**	**Work Phone**	**Email Address**	
DOB **Marital Status**			☐ **Male** ☐ **Female**
Employer **Occupation**	**Address**	**Phone**	
Emergency Contact	**Relationship**	**Phone**	

Ethnicity: (please circle one) Hispanic / Non-hispanic / Decline to specify	**Preferred Language:** English or Other:	**Race:** White / American Indian / Asian African American / Hawaiian / Decline to specify
Pharmacy: **Address:** **Phone:**		
Primary Care Physician (Full Name & City)	**Referring Provider (Full Name & City)**	
Eye Doctor (Full Name & City)	**Cardiologist (If Applicable)**	

INSURANCE INFORMATION

Primary Insurance Name:	**Secondary Insurance Name:**
Subscriber/Policy Holder Name: **Birth Date:**	**Subscriber/Policy Holder Name:** **Birth Date:**
Relationship To Patient:	**Relationship To Patient:**
ID #: **Group #:**	**ID #:** **Group #:**

IF PATIENT IS A MINOR

Father's Name:	**Mother's Name:**
DOB: **Phone #:**	**DOB:** **Phone #:**
By signing this form below, I give parental consent for Dr. Ko to evaluate and treat my minor child.	

FOR INJURIES ONLY

Date of Injury:	☐ **Work** ☐ **Auto** ☐ **Other (Please Explain)**
For Work Injury: Was a C-4 Completed?	☐ **Yes** ☐ **No**

Worker's Compensation Insurance Company Name:

For Auto Injury: Claim #
Insurance Adjuster's Name **Phone #**

I hereby authorize Nevada Eye Plastic Surgery to furnish to the above insurance companies or to a designated attorney all information which said insurance companies or attorney may request. I hereby assign Nevada Eye Plastic Surgery money to which I am entitled for medical and/or surgical expense relative to the services rendered but not to exceed my indebtedness to said physician and/or surgeon. It is understood that any money received from the above-named insurance company over and above my indebtedness will be refunded to me when my bill is paid in full. I understand I am financially responsible for any balance should this not be covered by my insurance. I further agree in the event of nonpayment to bear the cost of collection and/or court costs and legal fees required. I also authorize any medical photography or testing to be done as needed. By signing below, I also agree to abide by all office policies.

Signature _____ **Date** _____

Marcus J. Ko, M.D.
Cosmetic and Reconstructive Eyelid Plastic Surgery
Orbital and Lacrimal Surgery

NEVADA EYE PLASTIC SURGERY

Financial Information

_____ **Our office is here to help our patients. Please treat us with kindness and we will do our best to provide the same. Any individuals exhibiting disruptive or ill-tempered behavior, will be immediately discharged from the practiced and directed to find another provider for their care.**

_____ I understand that I, as the patient, am fully responsible for payment on my account with Nevada Eye Plastic Surgery (NEPS), regardless of insurance status. It is also my responsibility to inform the office of any billing and insurance changes as soon as possible, otherwise I may be responsible for the full billed charges if my insurance timely filing deadline has passed.

Every effort will be made to obtain prior authorization (PA), obtain eligibility and bill my insurance company. But I understand that it is ultimately my responsibility to know the specifics of my plan including coinsurance, deductible amounts and prior authorization (PA) or referral requirements. Copays and/or deductible are due at the time services are rendered.

These quoted amounts are ***only estimates*** and were obtained from my insurance company. The final amount owed cannot be definitively determined, until my claim is processed and paid. I understand that there is a possibility that the owed amount may be substantially higher than expected. If this is not acceptable to me, I will cancel my appointment and find another provider.

Lastly, I understand that NEPS is not contracted with **Tricare**, **Humana, some Blue cross Blue Shield plans and most Medicaid plans.** This list can change yearly. All attempts will be made to bill these insurance companies on my behalf. However, if services are denied, I understand that all charges will be my responsibility since NEPS is not contracted with these plans.

_____ **FMLA or forms**

I understand that a $20.00 administrative fee will be charged for all health-related forms.

_____ **No Show Policy or Late Cancel**

If you need to cancel or reschedule your appointment, please give us **24 hour notice.** If you "NO CALL, NO SHOW" to your appointment, you will be charged $75.00 to reschedule.

Surgery slots are extremely difficult to fill on short notice since most of our patients need to stop blood thinners. Please give us **2 weeks' notice if you need to reschedule or cancel your surgery.** Otherwise, you will be charged a late surgery cancellation fee of $200.00. After two late surgery cancellations, the practice reserves the right to not reschedule your surgery.

_____ **Collections & NSF Checks**

I agree to pay all attorney fees and/or all collection fees should collection proceedings become necessary. I understand that the collection agency charges a 40% fee and that this amount will be passed onto me if my account is sent to collections. Should this occur, I understand that I will be discharged from the practice and will no longer be seen as patient. The next nearest specialist is in Sacramento, CA or Las Vegas, NV. I also understand that a charge of $25.00 will be assessed for any unpaid or dishonored checks returned by the bank.

I have read the above financial agreement which outlines our office policies. By signing below, I understand and agree to the above terms:

Signature **Date**

Marcus J. Ko, M.D.
Cosmetic and Reconstructive Eyelid Plastic Surgery
Orbital and Lacrimal Surgery

NEVADA EYE PLASTIC SURGERY

Patient Name _____

Patient Authorization for Release of Information

I give Nevada Eye Plastic Surgery permission to release the following checked information to the following individuals.
You must notify the office in "writing" if you need to change or revoke any part of this authorization

Name	Relationship	Appt. Info	Billing Info	All Medical Info (including diagnosis)

Voice messages

☐ I give Nevada Eye Plastic Surgery permission to leave a detailed message with medically sensitive information on my voicemail at this phone number _____

☐ Please do not leave any detailed messages on my voicemail

HIPAA Notice of Privacy Practices

By signing below, you agree that our practice has offered you a copy of our HIPAA Notice of Privacy Practices electronically which can be viewed and/or printed from our website at www.nveyeplasticsurgery.com.

Permission to share Photos

Patients often ask for before and after photographs of our previous patients. If applicable, Nevada Eye Plastic Surgery would like to get your permission to lawfully share before and after surgery photographs in print and/or electronic/website form for illustration and advertising purposes. Efforts will be made to reveal the applicable surgery sites and to minimize identifiable features in the photograph.
Please indicate if you give us permission.

☐ Yes
☐ No

Dilated Eye Exams

I understand that Dr. Ko is an oculoplastic surgeon and therefore does **not** perform routine, **dilated** eye exams to diagnose eye conditions like macular degeneration or glaucoma. Please ensure you see your primary eye care provider for routine eye exams in addition to seeing Dr. Ko for your oculoplastic care. If you do not have an eye doctor, we would be happy to recommend some excellent doctors.

Signature **Date**

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Reno, NV 89511

Directions from Sparks

Take I-580/395 South
Take exit 31-S Virginia St/Kietzke Ln
Veer right towards Virginia St

- < Turn left onto S Virginia St
- < Turn left onto S McCarran Blvd
- > Turn right onto Airway Dr (this street eventually becomes Double R)
- < Once you **PASS LONGLEY LN**, make the **FIRST LEFT** turn onto Reno Corporate Dr

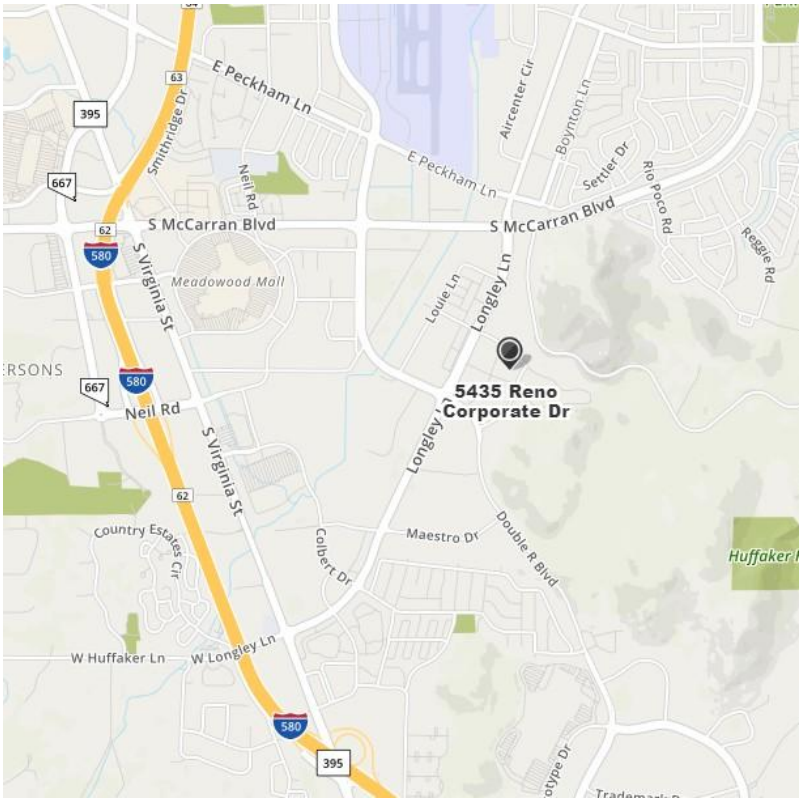
Our office will be on the left:
5435 Reno Corporate Dr. Ste 100

OR

Take McCarran Blvd heading South

- < Turn left onto Longley Ln
- < Turn left onto Double R Blvd
- < Make the **FIRST LEFT** turn onto Reno Corporate Dr

Our office building will be on the left:
5435 Reno Corporate Dr. Ste 100



Directions from Carson City:

Take I-580/395 North
Take the exit 29–S Virginia St

- > Turn right onto S Virginia St
- > Turn right onto Longley Ln
- > Turn right onto Double R Blvd
- < Make the **FIRST LEFT** turn onto Reno Corporate Drive

Our office will be on the left hand side:
5435 Reno Corporate Dr. Ste 100