

Nevada Eye Plastic Surgery
5435 Reno Corporate Drive, Suite 100
Reno, NV 89511



Welcome to the practice of Dr. Katie Topping, who is the only fellowship trained Oculoplastic (Eyelid Plastic) Specialist in Northern Nevada.

Please complete the enclosed forms and bring these, along with your insurance cards, medication list and photo identification to your appointment. Please arrive 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, Dr. Topping 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 before 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 not contracted with Tricare, Humana, most Medicaid plans and Anthem Blue Cross Blue Shield. We also do not accept any Aetna Medicare 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.

Please turn off all cell phones while in the office, and unless your 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 are 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 will provide you with access to your patient portal where you may look up your basic medical information. If you provide us with your email, you will automatically be invited to our Follow My Health 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 INFORMATION			
Last Name	First Name	MI	
Mailing Address	City	State	Zip
Home Phone	Cell Phone	Work Phone	Email Address
DOB	Marital Status	<input type="checkbox"/> Male <input type="checkbox"/> 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:
Social Security #:	Relationship To Patient:	Social Security #:	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. Topping to evaluate and treat my minor child.			
FOR INJURIES ONLY			
Date of Injury:	<input type="checkbox"/> Work <input type="checkbox"/> Auto <input type="checkbox"/> Other (Please Explain)		
For Work Injury: Was a C-4 Completed?	<input type="checkbox"/> Yes <input type="checkbox"/> 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 _____

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? _____
 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.)

How often have you had more than 4-5 alcoholic drinks/day in the last one year? _____

If you're diabetic, have you have a dilated eye exam or exam with retinal photos in the last 1 year? Yes No N/A
 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		
<input type="checkbox"/> Anxiety	<input type="checkbox"/> COPD	<input type="checkbox"/> Hypothyroidism
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Coronary Artery Disease	<input type="checkbox"/> Hyperthyroidism
<input type="checkbox"/> Asthma	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Skin : Basal Cell Carcinoma Squamous Cell Carcinoma Melanoma Cancer Locations/dates:
<input type="checkbox"/> Atrial Fibrillation (Irreg Heart beat)	<input type="checkbox"/> Hepatitis – Type:	
<input type="checkbox"/> Autoimmune Disorders (Please specify)	<input type="checkbox"/> High blood pressure	
<input type="checkbox"/> Cancers (Please specify):	<input type="checkbox"/> High Cholesterol	
<input type="checkbox"/> Diabetes	<input type="checkbox"/> HIV/AIDS	

Please list any others: _____

Ocular History

Please check all that apply				
<input type="checkbox"/> Dry Eyes	<input type="checkbox"/> Cataract Surgery	Right	Left	Both
<input type="checkbox"/> Blindness	<input type="checkbox"/> Eye Lid Surgeries	Right	Left	Both
<input type="checkbox"/> Glaucoma		Right	Left	Both
<input type="checkbox"/> Graves' Thyroid Eye Disease	<input type="checkbox"/> Retinal Conditions	Right	Left	Both

Please list any others: _____

Katie L. Topping, M.D.

Cosmetic and Reconstructive Eyelid Plastic Surgery
Orbital and Lacrimal 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 practice 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, Anthem Blue cross Blue Shield plans and most Medicaid plans.** This list can change yearly.

_____ **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

Katie L. Topping, M.D.

Cosmetic and Reconstructive Eyelid Plastic Surgery
Orbital and Lacrimal 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. Topping 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. Topping for your oculoplastic care. If you do not have an eye doctor, we would be happy to recommend some excellent doctors.

Signature

Date

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

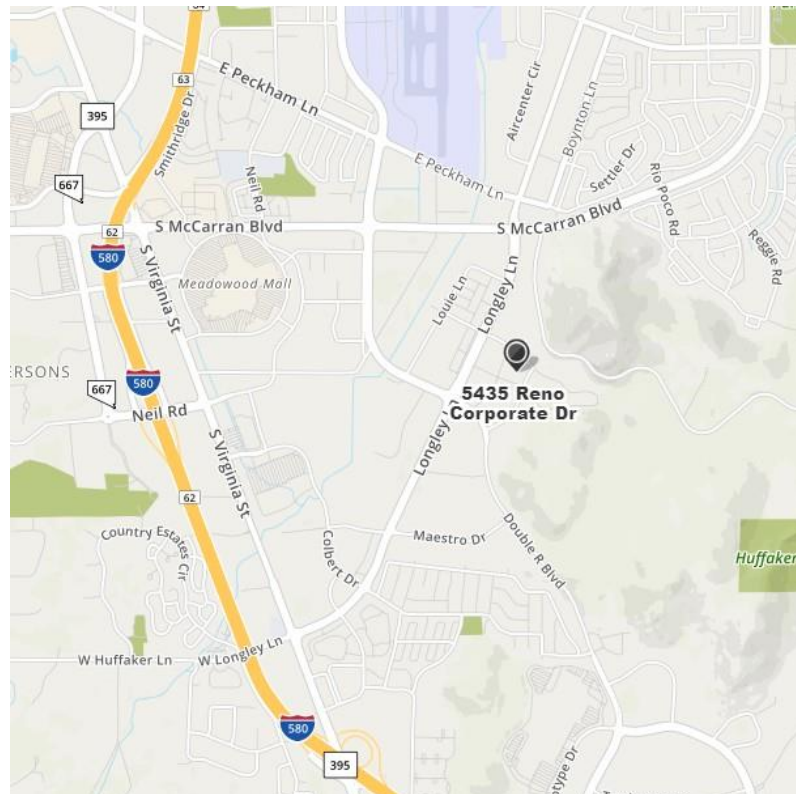
OR

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