

AWAKEN COSMETIC SURGERY CENTER
New Patient Information

PERSONAL INFORMATION (Please Print)

Name _____ Date _____
Date of Birth _____ Age _____ M / F Social Security # _____
Address _____
Street City State Zip
Phone: Home (____) _____ Work (____) _____ Cell (____) _____
Email: _____
Occupation _____ Employer _____
Address _____ Phone (____) _____
Marital Status: Single Married Widowed Divorced

Complete if under 18 years or a student

Name of Parent or Legal Guardian _____ Employer _____
Address _____ Phone (____) _____

REFERRED BY: _____

(Please mention who you were referred by, you or your friend may qualify for our special program)

Who to notify in emergency (nearest relative or friend)?

Name _____ Relationship _____
Address _____
Street City State Zip
Home Phone: (____) _____ Work Phone: (____) _____ Cell (____) _____

CONSENT FOR TREATMENT: The undersigned authorizes Dr. Liu and associates to provide treatment or procedures, which the provider considers necessary and proper in the treatment of the above named patients.

NO SHOW POLICY:

1. Patients who are confirmed for office based appointments or treatments and “no show” are subject to forfeiture of costs.
2. Patients who have paid in full for surgery and cancel are subject to 50% forfeiture.

LEGALITY:

1. Any legal dispute that arises with Awaken Cosmetic Surgery Center, the patient will be responsible for legal fees incurred by Awaken Your Eyes Oculoplastic Surgery.
2. Awaken Cosmetic Surgery Center reserves the right to decline further services to the patient for non-payment.

Acknowledgement of Receipt Notice of Privacy Practices

By my signature below, I acknowledge that I have been made aware of and have been provided information regarding the **Health Insurance Portability and Accountability Act (HIPAA)** and the Awaken Your Eyes Oculoplastic Surgery Notice of Privacy Practices.

Our office is fully committed to compliance with HIPAA guidelines by:

1. Providing appropriate security for our patient records.
2. Protecting the privacy of our patient’s medical information.
3. Providing our patients with proper access to their medical records.
4. Appropriately maintaining our patient information and billing processes in compliance with national standards.

If you would like a detailed copy of Notice of Privacy Practices, please ask the receptionist:

Model Release Photographic Authorization

In connection with the medical services which I am receiving from my physician, Dr. Alex Liu, I consent to photographs being taken of me or parts of my body under such conditions and at such times as may be approved by him. Moreover:

1. The photographs shall be taken by my physician or by a photographer approved by my physician and shall be used for medical records purposes, advertising copy, for any purposes of trade, advertising, exhibit, publicity, or promotion, without restrictions or limitations.
2. As the undersigned, I hereby give Dr. Liu, his legal representatives, those he assigns to act on his behalf the right to copyright any part of the photos, audio tape, video, film or other form of reproduction taken of me in any form, shape or composite, in which I may be distorted in character or form whether intentional or otherwise.
3. The photographs, digital images, or videos shall be used to instruct or edify other patients, potential patients or doctors exclusively for any reasons Dr. Liu deems necessary. I waive the right to approve or inspect the photographs, advertising copy, or printed matter used in conjunction therewith.
4. If in the judgment of my physician, medical research, education or science will be benefited by their use, such photographs and information relating to my case may be published and republished, either separately or in conjunction with each other, in professional or public journals or papers or medical books or the internet to be used for related purposes which he may deem appropriate without compensation to me. However, it is specifically understood that in any such publication or use, I shall not be identified by name.

Medical Status

Please answer the following questions about your health/medical status.

1. Please list any medications you are presently taking, including pain medications, eye medications, over the counter medicines, and any herbal supplements/vitamins.

2. Please list any previous cosmetic procedures including Botox, Juvederm/Restylane, chemical peels, microdermabrasion, laser skin treatments, other dermal fillers or fat injections.

3. Have you ever had surgery or been hospitalized? If yes, please explain.

4. Please list any medical diseases or eye diseases that run in your family.

5. Please list any medical diseases or eye diseases that you had as a child, especially if you had childhood eczema or acne.

6. Do you have any medical disease or medical conditions. Please include all conditions, even eye conditions.

7. Do you smoke Cigarettes or use any tobacco products? If yes, how much?

8. Do you drink alcohol? If yes, how much?

9. Do you have **ANY ALLERGIES**?

Do you currently have any of the following problems:

Chronic fever?	Yes	No
Fatigue?	Yes	No
Unexpected weight loss or gain?	Yes	No
Eye, ear, nose, or throat problems?	Yes	No
Heart problems, chest pain, or irregular heart beat?	Yes	No
Respiratory problems, shortness of breath, coughing or wheezing?	Yes	No
Gastrointestinal problems, heartburn, abdominal pain or diarrhea?	Yes	No
Urinary problems, pain urinating, discomfort or blood in urine?	Yes	No
Skin problems, rashes or excessive dryness?	Yes	No
Musculoskeletal problems, muscle aches or joint pain?	Yes	No
Neurological problems, headaches, numbness, weakness or paralysis?	Yes	No
Psychiatric problems, anxiety or depression?	Yes	No

Patient Name (Printed) _____

Patient Signature _____

Date _____

Awaken Cosmetic Surgery Center

Written Financial Policy

Thank you for choosing Awaken Cosmetic Surgery Center. Our primary mission is to deliver the best and most comprehensive medical and cosmetic care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Mastercard, American Express, Discover Card, Cash or Check, Visa
- NO INTEREST¹ Payment Plans² from CareCredit
 - o Allow you to pay over time with NO INTEREST¹
 - o Convenient, low monthly payment plans² also available
 - o No annual fees or pre-payment penalties

Please note:

Awaken Cosmetic Surgery Center requires payment prior to the beginning of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

For larger, more comprehensive treatment plans of \$500 or more, a 20% deposit is required to secure your surgical treatment appointment.

For patients with medical insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.

Awaken Cosmetic Surgery Center charges \$25 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the medical and cosmetic treatment you want and need.

Patient, Parent or Guardian Signature

Date

Patient Name (Please Print)

¹If paid within the promotional period. Otherwise, interest assessed from purchase date. Minimum monthly payment required.

²Subject to credit approval

³However, if we do not receive payment from your insurance carrier within 120 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.