

AWAKEN YOUR EYES OCULOPLASTIC SURGERY
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

Spouse Name _____ Employer _____

Address _____ Phone (____) _____

Complete if under 18 years or a student

Name of Parent or Legal Guardian _____ Employer _____

Address _____ Phone (____) _____

Primary Physician: _____ (Phone) _____

(Address) _____

REFERRED BY: Friend/Relative _____ Doctor _____

Name Name
 Yellow Pages Television Newspaper Other _____

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

INSURANCE INFORMATION

Medicare # _____ (Please submit insurance cards for copying)

Other Medical Insurance _____

Group # _____ ID # _____

Other Medical Insurance _____

Group # _____ ID # _____

Are you personally responsible for the payment of your fees? Yes No If not, who is?

Name _____ Relationship _____ DOB _____

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

Name _____ Relationship _____

Address _____

Street City State Zip

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

MEDICATION/FOOD ALLERGIES:

AWAKEN YOUR EYES OCULOPLASTIC SURGERY

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.

RELEASE OF RECORDS: I hereby authorize the provider to furnish insurance companies with any information concerning my treatment which may be requested, including photocopies of my patient records as necessary for completion of my claim or as may be required by law. I further authorize the provider to furnish information from my patient records pertaining to the treatment as requested by other doctors or medical care facilities for continued care treatment.

FINANCIAL ASSIGNMENT AND AGREEMENT:

1. **Dr. Liu ONLY accepts MEDICARE and no other insurances; reimbursement of payment of the exam & procedure is the patient's responsibility outside of Medicare. Dr. Liu will help you with the process of being reimbursed by your insurances as a non-participating physician but cannot accept responsibility for collecting any insurance claim or negotiating any settlement on a disputed claim.**
2. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.**
3. **Patients' accounts are due at the time treatment is given or at the conclusion of each office visit Unless other arrangements are made or the treatments/procedures/exams are covered by Medicare.**
4. I request that payment of authorized Medicare benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration, its agents, or any insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services.

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 Your Eyes Oculoplastic Surgery, the patient will be responsible for legal fees incurred by Awaken Your Eyes Oculoplastic Surgery.
2. Awaken Your Eyes Oculoplastic Surgery reserves the right to decline further services to the patient for non-payment.

CONSULTATION FEE: The undersigned understands there is a \$95 consultation fee due for all new patients that may be applied to any procedure or treatments rendered.

I hereby assign medical and/or surgical benefits, to which I am entitled by Medicare to Awaken Your Eyes Oculoplastic Surgery. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by my insurance or Medicare. I hereby authorize said assignee to release all information necessary to secure the payment.

Signed (Patient or legal guardian if minor) _____ Date _____

AWAKEN YOUR EYES OCULOPLASTIC SURGERY

Authorization for Release of Confidential Information

I, _____ (print name) hereby authorize

To release medical information contained in my record to:

Alex Liu, MD

_____ (Patient Signature or Legal Guardian) _____ (date)

_____ (witness)

AWAKEN YOUR EYES OCULOPLASTIC SURGERY

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.

I hereby warrant that I have read this release agreement in its entirety before affixing my signature and I fully understand the contents therein. I further warrant I am of legal age and competent to contract in my own name as far as the above is concerned.

_____ (Patient name)

_____ (Signature)

_____ (Date)

Medical Status Form

_____ (Patient's name) _____ (date)

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 use any illicit drugs? If yes, how much and which ones?

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