THE EYELID INSTITUTE

41990 Cook St BLDG F #1007 Palm Desert CA, 92211 Tel: 760-610-2677 Fax: 760-610-6101

PATIENT INFORMATION

Date: _____

Last Name _____ Middle Initial _____ First Name _____

DOB _____ Age _____ SSN _____ Sex ☐M ☐F

Billing Address: _____

City/Zip: _____

Home Ph _____ Cell Ph _____ Email _____

Employer: _____ Work Phone: _____

If Insurance is through spouse/parent please provide following information:

Name: _____ DOB _____ SSN _____

Emergency Contact_____ Relation _____ Ph # _____

How did you hear about us? _____

Primary Physician _____ Send Correspondence Y / N

Additional Physician _____ Send Correspondence Y / N

AUTHORIZATION FOR TREATMENT: I hereby authorize Dr. Jennifer Hui of The Eyelid Institute to render medical and surgical treatment for my condition(s).

ASSIGNMENT OF BENEFITS: I assign all medical and/or surgical benefits including major medical benefits to which I am entitled, including Medicare, private insurance and any other health plan to The Eyelid Institute/Jennifer Hui, MD. This assignment shall remain in effect until revoked by me in writing. I hereby authorize the release of all information to secure payment. A photocopy of this assignment is to be considered as valid as an original. As a courtesy, the office will bill my primary insurance carrier for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance, or in the event that I do not provide timely or accurate insurance information, within 30 days of service. I further agree, in the event of non-payment, to bear the cost of collection and/or court cost and reasonable legal fees should this be required.

NOTICE OF PRIVACY PRACTICES (ACKNOWLEDGEMENT OF RECEIPT): I acknowledge that I have been given the opportunity to read the NOTICE OF PRIVACY PRACTICES for the offices of Jennifer Hui, M.D., a copy of which is available in the reception area. I understand that a copy of this notice will be made available to me at my request.

_____ _____

INSURED OR GUARDIAN'S SIGNATURE PATIENT'S SIGNATURE

THE EYELID INSTITUTE

PATIENT CONSENT FOR MEDICAL PHOTOGRAPHY

CONSENTIMIENTO DEL PACIENTE PARA FOTOGRAFIA MEDICA

Patient Name: _____ _____ Date: _____
(Nombre) *(Fecha)*

I consent for medical photographs to be taken of me or my child (or person for whom I am legal guardian). I understand that the information may be used in my medical record. By consenting to these medical photographs, I understand that I will not receive payment from any party. Refusal to consent to photographs will in no way affect the medical care I will receive.

Doy mi consentimiento para fotografías médicas se hagan de mí o mi hijo (o la persona por quien yo soy tutor legal). Entiendo que la información puede ser utilizada en mi expediente médico. De acuerdo con estas fotografías médicas, entiendo que no recibiré pago de cualquier partido. La negativa a dar su consentimiento a las fotografías de ninguna manera afectar la atención médica que va a recibir.

_____ Signature*(Firma)* _____ Witness

For patients between ages 7 and 18, a signature below indicates that the information in this consent form has been explained to me, and I attest the use of my images as outlined above:

Para los pacientes entre las edades de 7 y 18 años, una firma a continuación indica que la información de este formulario de consentimiento se ha explicado a mí, y doy fe de la utilización de mis imágenes como se describe más arriba:

_____ Signature of Patient _____ Witness
(Firma de Paciente)

PARTNERSHIP AGREEMENT

You are establishing a partnership with our practice. We look forward to a productive, harmonious working relationship. In order to achieve this you agree:

1) To follow all medical advice and treatment plans;
2) To be respectful with office staff at all times as this office has a zero tolerance policy for inappropriate behavior;
3) To follow up on any outstanding pending results (labs, tests, imaging, biopsies, etc) and referrals to other providers in a timely fashion. You accept full responsibility for your (or your child's) medical care.
4) That two or more no show appointments/last minute cancellations will result in the end of this agreement and you will be unable to continue to be seen at this practice.

1) Seguir todos los consejos médicos y planes de tratamiento;
2) Ser respetuoso con el personal de oficina en todo momento ya que esta oficina tiene una política de tolerancia cero para el comportamiento inapropiado;
3) Seguimiento de los resultados pendientes (laboratorios, pruebas, imágenes, biopsias, etc) y remisiones a otros proveedores de manera oportuna. Usted acepta plena responsabilidad por su (o la de su hijo) atención médica.
4) Que dos o más citas de no presentación / cancelaciones de último minuto resultarán en el final de este acuerdo y no podrá continuar siendo visto en esta práctica.

I acknowledge that I have been informed of these policies and have had adequate opportunity to have any questions answered and agree to comply.

Yo reconozco que he sido informado de estas políticas y han tenido una adecuada oportunidad de tener alguna pregunta contestada.

_____ Signature(*Firma*) _____ Witness _____ Date (*fecha*)