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: _____ State: _____ Zip code: _____

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 _____

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

Patient Name: _____ Date: _____

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.

_____ Signature of Patient _____ 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:

_____ Signature of Guardian _____ Witness

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.

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

_____ Signature _____ Witness _____ Date

Name _____ DOB _____ Your age _____ Today's Date _____

Smoking history (***18y or older***) ➔ *Counseling: smoking is harmful to your health*

__ I have never smoked [1036F / G9903]

__ Currently smoke ___ Daily ___ Less than daily [4004F / G9902 / G9906 / G0030]

__ I am a former smoker [1036F] Approximate date I started_____/quit_____ [≥ ***18y*** *EM/EC 226]*

Do you have an advanced care plan or health care surrogate decision maker? (***65y or older***) ➔ *We recommend having a designated person*

__ Yes (Name of decision maker _____) [1123F]

__ No surrogate decision maker at this time [1124F] [≥ **65 y**/*EM 47*]

Body Mass Index screening ***(18y or older)*** ➔ *Please discuss optimizing your BMI with your primary care physician if it is <18.5/≥25*

_____ Height _____ Weight _____ BMI (we will calculate)

____ WNL [G8420] _____ <18.5 [G8418] _____ ≥ 25 [G8417] [≥18y EM 128]

High Blood Pressure Screening (***18 y or older***) ➔ *if your blood pressure is above 120/80 today, please discuss management w/ your PCP*

__ I have a known history of high blood pressure [G9744]

__ I do NOT have high blood pressure to my knowledge [G8783 – normal BP / G8950 – above 120/80] [**≥18y** EM/EC 317]

Diabetic Patients ***(18y or older)***

My most recent A1C was _____ on _____.

_____ <7 [3044F] / ____≥7 to <8 [3051F] / ≥8 to ≤ 9 [3052F] / ____> 9 [3046F] [**18-75y** EM 1/ **E11.00**]

Fall risk ***(65y or older)*** [0518F]

__ I have fallen 2 or more times in the past year ➔ *you should consider working with physical therapy (we can refer you)*

__ I have fallen once and sustained injury in the last year ➔ *you should consider working with physical therapy (we can refer you)* [≥ 65y / EM 155]

Medication documentation (for pts aged 18y and older) – Please list medication **changes** since last visit

___ documented and reviewed [G8427] [**≥18y** EM/EC 130]

OFFICE USE ONLY

Referral Loop (all pts)

Pt referred to Dr. _____ [G9968]

Report not received [G9970]

Report received on _____ [G9969] [**all ages** EM/EC 374]