NEW PATIENT INFORMATION

Date:_____

Legal Name: _____
Preferred Name:_____
Address:_____
City/State/Zip:_____
Driver's License #:_____
Birthdate: ____/_____/_____ Age: _____
Ethnicity: _____

Preferred Method of Contact:_____
Phone: (hm)_____
(cell)_____
(wrk)_____
Email Address_____

Height: _____ft_____in Weight: _____lbs
Gender: Male/Female/Other

Employer: _____ Phone #:_____
Occupation: _____
Emergency Contact (phone # & relationship): _____
REASON FOR INITIAL VISIT: _____

HOW DID YOU HEAR ABOUT US? Circle all that apply.

Self - Friend/Family - Phone Book - Magazine - Newspaper - Internet - Physician - Other

If you found us on the internet, which website did you find us on?
ILoveLO.com - Google - Yahoo - Facebook - LOMC - Other:_____

Referring Doctor (name):_____
Address:_____
City/State/Zip:_____
Phone Number:_____

Primary Care Physician (name):_____
Address:_____
City/State/Zip:_____
Phone Number:_____

INSURANCE INFORMATION (SUBSCRIBER INFORMATION IS REQUIRED):

Relationship to patient: □ Self □ Spouse □ Child □ Other: _____
Subscriber Name:_____
Date of Birth:_____
Address:_____

Phone #:_____
Social Security Number:_____
City/State/Zip:_____

Primary Insurance:_____
Policy holders Name:_____
ID#:_____
Group #:_____
Address:_____
Phone #:_____

Secondary Insurance:_____
Policy holders name:_____
ID#:_____
Group #:_____
Address:_____
Phone #:_____

Signed: _____ Date: _____
Patient's Signature/Guardian Signature

Please list all previous surgeries, serious injuries, illnesses or diseases *(If more room is needed, please list on separate sheet)*

Type	Year	Surgeon/Physician	City/State

History of motion sickness or postoperative nausea/vomiting? Yes No

Personal or family history of anesthesia problems? Yes No

Next Dental Cleaning:_____ Valium/Sedation Needed with Dental Procedures? Yes No

Please list any allergies: (example: Penicillin, Sulfa, Iodine, Seafood, Codeine, Anesthesia, Paper Tape, Medipore Tape, Steristrips, Eggs, Milk, Dye)

NO ALLERGIES _____

LATEX allergy? Yes / No / Sensitivity
History of herpes? Yes / No : Oral /Genital

Food/Drug	Reaction

Pharmacy of choice (name): _____

Current Medications: (please include herbal supplements, any additional please add on the back)

Name of drug:	Dose (mg):	How often taken:	Reason for taking:

Are you currently taking any of the following: Aspirin Ibuprofen Fish Oil Methadone/Buprenorphine

Are you currently on pain Medication? Vicodin Percocet Oxycodone Suboxone Other:_____

Medical Conditions, which seem to run in your family. *(i.e. heart attacks, blood clots, diabetes, anesthesia problems)*

_____ _____

Have you ever smoked? ___Yes___No When? _____Quit? _____
Do you smoke tobacco? ___Yes___No How much?_____Quit?_____
Do you smoke marijuana? ___Yes___No How often?_____Quit?_____
Do you use non-prescription drugs: ___Yes___No What & How much?_____
Do you drink alcohol? ___Yes___No What & How much?_____

Do you have history of substance abuse or alcoholism? ___Yes ___No
If yes to either, please provide active counselor's info:_____

For women: Are you pregnant? ___Yes ___No ___Maybe

MEDICAL HISTORY:

Do you previously/currently have any of the following medical problems? (Please circle or add)

Constitutional: Recent unexpected weight loss, change in appetite, problems sleeping, fever, other.
Details: _____

Eyes: Dry eyes, glasses, contacts, vision changes, other.
Details: _____

Ears, Nose, Mouth, Throat: hearing aids, seasonal allergies, nosebleeds, difficulty breathing, previous injury, other.
Details: _____

Cardiovascular: high blood pressure, heart murmur (antibiotics needed prior to dental procedure), valve narrowing, aortic aneurism (dilated/weakened vessels), heart attack, irregular heartbeat, mitral valve prolapse, other.
Details: _____

Respiratory: pneumonia, asthma, smoking, COPD, sleep apnea, severe snoring, **CPAP/Breathing machine** use.
Details: _____

Gastrointestinal, Pancreas, Liver: ulcers, bleeding, chronic diarrhea, abdominal pain, pancreatitis, hepatitis, liver disease.
Details: _____

Musculoskeletal: neck joint stiffness, carpal tunnel, joint replacement, muscle problems, broken bones, gout, other.
Details: _____

Renal: kidney problems, urine problems (urinary tract infections), bladder problems, other.
Details: _____

Skin/Breast: skin rash or problems, acne, Accutane use, bronzing solution use, tanning bed use, breast cancer/surgery, breast lumps, breast biopsies, breast radiation, lymph node biopsy, skin cancer, other.
Details: _____

Neurological: seizure, head injury, stroke, neuropathy, nerve disease, headaches, migraines, post-operative nausea/vomiting, fainting, other.
Details: _____

Endocrine: thyroid, diabetes, high sugars, hormonal problems, other
Details: _____

Hematologic/Lymphatic: anemia, bleeding tendencies, bruise easily, blood thinners (i.e. Warfarin), DVT (deep venous thrombosis) or PE (pulmonary embolism), blood clots, phlebitis, other.
Details: _____

Allergic/Immunologic: anaphylactic reactions, HIV/AIDs, TB (tuberculosis), prolonged or persistent infections, other.
Details: _____

Other: fibromyalgia, depression, anxiety, stress, psychiatric problems, cancer, MRSA, other.
Details: _____

None of the Above ☐

CONSENT FOR PHOTO-TAKING

Please read and initial each point you wish to give your consent.

_____ I consent to have my photograph(s) taken to assist in my evaluation medical treatment and follow-up. Photos taken are only of the area of concern and are for Dr. Hu's evaluation only. **

_____ I consent to the use of photographs taken of me, for the discussion with other trained Plastic Surgeons or of those practicing as Plastic Surgeons.

_____ I consent for the use of any record, illustration, photograph, or other imaging record created in my case, for use in examination, credentialing, and certifying purposes by The American Board of Plastic Surgery and Dr. Hu.

_____ _____

Patient/Guardian Signature Date

****PLEASE NOTE:**
Photos are being taken for the purpose of "Before" & "After" photos.
They will NOT be used on our website.
They will NOT be used in our photo book.
A separate consent for photo sharing is presented for photobook and website sharing.

COSMETIC & SELF-PAY CONSULTATIONS/PROCEDURES POLICY:

If Dr. Hu determines that you are a good candidate for cosmetic and/or self-pay procedures, you will be presented with a price quote at the end of your consultation.

1. **Consultation Appointment and Office Visit Fee Policy**: There is a non-refundable/non-transferrable $100 consultation fee. This fee is collected at the time of scheduling your consultation appointment. Future visits not related to in-office procedures or pre/postoperative care will have a $100 office visit fee.

2. **Payment**: For your convenience, we accept Cash/Cashier Checks, Visa, MasterCard, Discover, American Express and Care Credit. Personal checks are accepted up to 14 days prior to the consult and/or treatment date.

3. **Credit Card on File Policy**: We recommend keeping your credit or debit card of choice on file as a convenient method of payment. Your credit card information is kept confidential and secure. Charges to your card are processed with your authorization (verbal or written).

4. **Injectable Procedures and Product Sales:** Filler appointments require a 50% deposit to secure your time. The balance will be collected on day of treatment. Payment for injectables such as Botox® and Dysport® will be collected on the day of, prior to the treatment. Personal checks will not be accepted. For all purchased product items in the office (i.e. skincare, sunscreens, etc.), there will be no returns or refunds available. All sales are final.

5. **Office-Based Self-Pay Procedures**: The procedure fee quote includes Dr. Hu's fee and supplies necessary for your surgery. It will also include your office follow-up visits for six months following the procedure. Quoted fees are honored for 90 days from the day of quotation. There is a $500 non-refundable deposit due at the time of scheduling your in-office procedure. This deposit secures your date for the procedure and the quoted cost. If postponed, the deposit will be credited to the rescheduled procedure date. The remaining balance will be collected at the time of procedure. *Please see price quote given at your consult for more information.

6. **Facility-Based Self-Pay Procedures**: The procedure fee quote includes Dr. Hu's fee, hospital operative room fees, anesthesiology fees and implants/garments necessary for your surgery. It will also include your pre-operative visit before surgery and office follow-up visits for one year following surgery. Quoted fees are honored for 90 days from the day of quotation. There is a 25% or $500 non-refundable deposit (whichever is greater) due at the time of scheduling surgery that will be applied towards the surgeon's fee. This deposit secures your date for surgery. The remaining balance is due at the pre-operative visit, typically 2 weeks prior to your surgery date. Full payment for surgeries MUST be received at least 14 days before surgery or your surgery date will be forfeited. *Please see price quote given at your consult for more information.

7. **Cancellation Policy**:
    a. More than 14-day notice: you will receive an 80% refund of the surgeon's fee, minus the non-refundable deposit.
    b. Less than 14-day notice: you will receive a 50% refund of the surgeon's fee, minus the non-refundable deposit.
    c. If Dr. Hu cancels your procedure due to medical reasons and you cannot be rescheduled within 90 days of the initial surgery date, you will receive a 100% refund of the surgeon's fee.
    d. Cancellation policies for facilities and anesthesia will vary by location.

8. After surgery, it is possible that additional related surgeries will be necessary. It is important to understand that the patient is completely responsible for the operating room expenses, anesthesia fees and a percentage of the surgeon's fee.

INSURANCE CONSULTATIONS/PROCEDURES POLICY:

Please remember that insurance is a contract between you, your employer, and the insurance company. You are fully responsible for all fees charged regardless of your insurance coverage. Accepting your insurance does not place all financial responsibilities onto this practice, and you will be held accountable for any unpaid balances by your plan. There are many different insurance plans and within each of these plans, there are different benefits per each person's type of coverage. It is important that you understand exactly what your benefits are when you access health care services. Please take the time to read the policies below and check with your insurance provider if you have any questions about your coverage.

1. **Office Visits**: Payment is expected at time of service for specialist co-pay; any amounts due for patients who are "self-pay"; any amounts due from previous dates of services or any additional amounts that may be incurred during your current visit. Co-payments must be paid at check-in of each visit or your appointment will be rescheduled. Per our contract, we are required to collect these co-payments. At your visit checkout, you may be billed for any additional balances if a procedure is performed during your visit. If there is a credit due, you will be provided a refund within 30 days. With the card holder's authorization, we will charge the outstanding patient responsibility balances due 60 days after services rendered, with prior notification to you. _____ (Initials)

2. **Procedure Appointments**: If you are covered by insurance, it is expected that you will pay an estimated portion of your deductible and/or expected co-insurance (amounts as stated in the benefits coverage contract with your insurance carrier) before the procedure. This estimate of charges will be determined after your consultation appointment and determination of appropriate procedure codes. Based on your benefits and deductible plan, we will provide an estimate of your potential out-of-pocket costs for the surgeon fee portion of the insurance-covered procedure (does not include facility or anesthesia fees). To secure your surgery date, a $500 deposit will be taken at the time of scheduling your procedure, and payments for the remaining patient balance start within 60 days of the procedure date. A payment plan will be determined prior to the procedure. If there is a default in payments, an "outstanding balance" charge of 1.5% of the remaining bill that will be charged each month that the bill remains unpaid (unless a payment plan has been arranged). _____ (Initials)

3. **Payment**: For your convenience, we accept Cash/Cashier Checks, Visa, MasterCard, Discover, American Express, Care Credit, Health Savings Accounts and Personal Checks as forms of payment. A valid picture ID is required on all checks. If your check is returned for insufficient funds, a $35.00 returned check fee will be added to your outstanding balance. _____ (Initials)

4. **Credit Card on File Policy**: We require keeping your credit/debit card of choice on file as a convenient method of payment for the portion of services that your insurance does not cover, but for which you are liable. Your credit/debit card information is kept confidential and secure. Charges to your card are processed based on your written authorization. Without this authorization, a monthly billing fee of $5 will be added to your account for any balances that we must attempt to collect. _____ (Initials)

5. **Insurance**: As a courtesy, our practice will check a benefits quote with your insurance company. Although we are contracted with most insurance carriers, our services may not be covered by your particular insurance plan. A quote of benefits is not a guarantee of benefits or payment. Your claim will process per your plan. If your claim processes differently from the benefits we were quoted, the insurance company will side with that plan and will not honor the benefit quote we received. For your convenience, we will gladly assist you in submitting claims to your insurance company, provided that you have supplied us with complete and accurate insurance information, as well as home address, telephone, and employer information. This courtesy service is provided by a billing service separate from our office. If you have more than one insurance, the claim will first be filed with your primary insurance, and once consideration has been made, it will then be filed with the secondary insurance. If your secondary insurance does not pay within 30 days, the balance becomes your responsibility. Do not assume that you will not owe anything if you have more than one insurance policy. Please bring your insurance card and driver's license to every visit so that we can confirm your coverage. Otherwise, the visit will be considered self-pay ($100 per visit). This is to protect your benefits so that no one else may fraudulently access your health insurance. If you cannot provide proof of coverage you will be treated as a self-pay patient (see page 5). If your insurance changes, please notify us before your next visit so we can make the appropriate changes to your billing information. _____ (Initials)

6. **Medicare**: Medicare will cover 80% of their allowable charges; you will be responsible for the remaining 20%. Non-covered medical charges are also your responsibility. You will be notified of those services that may not be a Medicare covered benefit in advance and be allowed to decline those services. In these circumstances, you will be asked to sign an Advanced Beneficiary Notice (ABN) that describes the service(s) the doctor is recommending that may not be covered by Medicare. If you have a secondary insurance, we will be happy to bill them on your behalf. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request in a timely matter. If your secondary insurance does not pay within 30 days after the procedure, the balance becomes your responsibility. Remember, you are responsible for your medical charges whether or not your insurance company pays your claim. _____ (Initials)

7. **Medicare Replacement Plans**: Many patients who qualify for Medicare have chosen to sign up for a Medicare Replacement Plan, which functions as a HMO. If you have one of these plans, you do NOT have Medicare; you have a Medicare Replacement Plan. This is an important difference because each of these plans have different requirements for how you access your health care – which doctors you can see and which hospitals you can use, for example. Please make sure you know your benefits and your responsibilities with these plans. These plans typically have a copay, which will be collected at check in for each appointment. _____ (Initials)

8. **Insurance Referrals and Authorizations**: If a referral is required by your insurance carrier, you will be asked to obtain the referral authorization **prior** to your appointment. Many Medicare Replacement Plans and HMO insurance plans require a referral from your Primary Care Provider (PCP) to cover most specialist services. If you do not have the appropriate referral authorization on file, your appointment may be cancelled or you will be responsible for the full cost of services rendered. Your insurance contract is between you and your insurance company, thus you will ultimately be 100% responsible for all charges incurred. Our office will obtain the necessary authorization for procedures prior to scheduling a procedure or surgical appointment. Incorrect information can significantly delay the prior-authorization process for your surgery. Being referred to our clinic by another physician does not necessarily guarantee that your insurance will cover our services. Please check with your insurance company or PCP to confirm that you have the correct referral and authorization for each visit. _____ (Initials)

9. **Delinquent Accounts Policy**: Patients who have unpaid balances will be required to make payment arrangements prior to scheduling their next appointment. When you have a personal balance, you will receive a monthly statement. Prompt payment of personal balances is greatly appreciated. Please call our billing service if you know your payment will be late arriving or if you require special payment arrangements. If you fail to pay your portion of the bill after our normal collection procedures, we may refer you to a collections agency and a collection fee of 35% will be added to any outstanding balance, along with all attorney and court fees and this will be your responsibility. Your insurance will not pay for this. In addition, you may be discharged from this practice. If this occurs, you will be notified by certified mail that you have 30 days to find alternative medical care. During that 30-day period, Dr. Hu will only treat you on an emergent basis. _____ (Initials)

10. **Forms Completion/Medical Records**: Should you request our office to complete forms on your behalf for disability, work status, FMLA, etc., there is a $25.00 fee per form, payable at the time they are requested. Please allow 7-10 business days for completion. There may also be a charge for other forms and letters, according to the complexity and time required to prepare them. There is no charge for medical records that are sent electronically to another physician for continuing care. There is no charge for an electronic personal copy; however, for a printed form, there is a charge at $0.10 per page. _____ (Initials)

11. **Appointment Cancellations/No Shows/Reschedules**: There is a $100 charge for those who cancel, re-schedule or no show for office visits without giving 24-hour notice. There is a $200 fee for a cancellation, re-schedule or no show for a procedure appointment without giving 72-hour notice. These charges will be billed directly to you as your responsibility. Your insurance will not pay them. Please help us to serve you best by keeping your regularly scheduled appointment. _____ (Initials)

12. **Late to Appointment Policy**: If you are up to 15 minutes late to your scheduled appointment, we reserve the right to re-schedule your appointment. If you are more than 15 minutes late to your scheduled appointment, the appointment will be cancelled, and you will be rescheduled. There is a $100 charge for same-day rescheduling. _____ (Initials)

13. **Assignment of Benefits and Release of Information**: I, the patient, assign the benefits from the insurance carrier(s) to Emily Hu, M.D., P.C. for the medical/surgical services for which I am entitled. I authorize the release of any medical or other information to my medical insurance company necessary to process my claim, authorize services, or coordinate treatment. _____ (Initials)

14. **Patient Responsibility**: I understand I am personally responsible for all medical expenses provided by Emily Hu, M.D. P.C., for medical care and treatment. I understand that I am responsible for advising Emily Hu, M.D., P.C. of any changes to my address, phone number, insurance plan, payer or coverage. I agree to pay all medical expenses within 30 days of the date I am billed for those expenses, unless other arrangements have been made with Dr. Hu's billing service. _____ (Initials)

All patients must complete and sign these payment policies and assignment and release of information agreement with the patient registration form prior to receiving care by Emily Hu, M.D., P.C.

By signing below, the patient or guarantor acknowledges that he/she has read, understands and agrees to comply with all policies above. Please bring this signed form to your appointment.

I have read, understand, and agree to these Financial Policies:

_____ _____

Patient/Guardian Signature Date

_____

Printed Name

CREDIT CARD ON FILE POLICY

At Emily Hu, MD, PC, we require keeping your credit or debit card on file as a convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are liable (your personal balance/financial responsibility).

For insurance patients only: without this authorization, a monthly billing fee of $5 will be added to your account for any balances that we must attempt to collect through mailing monthly statements. Balances are due on the FIRST of each month. After the 15th of the month, balances are considered past due, and will be charged an "outstanding balance" fee of 1.5 percent of the total bill for each month that the bill remains unpaid.

Your credit card information is kept confidential and secure and payments to your card are processed only after the claim has been filed/processed by your insurer, and the insurance company's portion of the claim has been paid and posted to your account.

I authorize Emily Hu, MD, PC to charge the portion of my bill that is **my financial responsibility** to the following credit or debit card:

☐ Amex ☐ Visa ☐ MasterCard ☐ Discover #: _____
Expiration Date _____ / _____ Security Code _____ (last 3 digits on back of the card)

The undersigned guarantees performance of the financial provisions of this agreement:
Cardholder Name _____
Billing Address _____
City _____State_____ Zip _____

Initial each line below:

____I, the undersigned, authorize and request Emily Hu, MD, PC to charge my credit or debit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility, and specifically authorize to charge my card for the services provided.
____I further agree that in the event my credit card becomes invalid, I will provide a new valid credit card upon request, to be charged for the payment of any outstanding balances owed.
____Charges made for actual services performed by our office are non-refundable.
____This authorization relates to all payments not covered by my insurance company for services provided to me by Emily Hu, MD, PC.
____This authorization will remain in effect until I cancel this authorization. To cancel, I must give a 60-day notification to Emily Hu, MD, PC in writing and the account must be in good standing.

Patient Signature: _____ Date: _____