EMPIRE EYE AND LASER CENTER / EMPIRE AESTHETIC CENTER

PATIENT INFORMATION FORM

PERSONAL INFORMATION

Patient Name:_____Preferred Name:_____

SS#:_____DOB: _____

Address: _____

City: _____ State: _____ ZIP: _____

Home Ph#: _____ Cell Ph#: _____ Work Ph#:_____

Email: _____

Preferred Phone#: ❑ Home ❑ Cell ❑ Work Preferred Contact Method: ❑ Text ❑ Email ❑ Phone

Race: _____

Ethnicity:_____

Preferred Pharmacy (include address): _____

Referring Physician:_____

Employer: _____ Occupation: _____

Address: _____

City: _____ State: _____ ZIP: _____

EMERGENCY CONTACT / SPOUSE / PARENT / RELATIVE INFORMATION

Name: _____ DOB: _____

Relationship to Patient: _____ Phone: _____

Employer: _____ Address: _____

I certify that the information on this form is correct to the best of my knowledge.

_____ _____

Patient Signature Date

*** PLEASE TURN PAGE OVER ***

EMPIRE EYE AND LASER CENTER / EMPIRE AESTHETIC CENTER

Patient Name: _____DOB: _____

ASSIGNMENT OF BENEFITS

I hereby assign all medical and/or surgical benefits to which I am entitled, including Medicare, private insurance, or any other health plans to Empire Eye and Laser Center. I hereby authorize said assignee to release all information necessary to secure payment. 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 not paid by my insurance, including non-covered services—such as refraction and cosmetic procedures.

AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize the use and disclosure of individually identifiable health information relating to me, which is called Protected Health Information (PHI), under a federal health privacy law. I further understand that my PHI may be used to carry out treatment, payment, or healthcare operations.

I understand that I may revoke this authorization at any time by notifying Empire Eye and Laser Center in writing.

I have received a copy Empire Eye and Laser Center's **Notice of Privacy Practices** prior to signing this consent.

I understand I have the right to restrict how my PHI is used or disclosed by notifying Empire Eye and Laser Center of my wishes in writing.

PATIENT FINANCIAL RESPONSIBILITY

I understand that I am ultimately responsible for all payment obligations arising out of my treatment or care and guarantee payment for these services.

I understand that I am responsible for deductibles, co-payments, coinsurance amounts or any other patient responsibility indicated by my insurance carrier, which are not otherwise covered by my primary or supplemental insurance.

ADDITIONAL FEE RESPONSIBILITY

I acknowledge that I am responsible for any additional fees charged by Empire Eye and Laser Center in accordance with their regular fee policy including no show fees, cancellation fees, additional form completion fees, medical record fees, and report fees. I also understand that these fees are not typically covered by my insurance carrier and I will be billed for these fees if incurred.

Full fee policies are posted on Empire Eye and Laser Center's website at www.empireeyeandlaser.com

PATIENT OPT-IN

By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due, lab results, or any other healthcare related function. I consent to receiving multiple messages per day from my healthcare provider, when necessary. I consent to allowing detailed messages being left on my voice mail, answering system, or with another individual, if I am unavailable at the number provided by me. By requesting a ride, I also consent to be contacted on my phone number on file (including by autodialer) about my trip.

_____ _____

Patient Signature Date

EMPIRE
AESTHETIC CENTER

Name:_____

DOB:_____ **Height:**_____ **Weight:**_____

Allergies to Medication(s): ❑ No ❑ Yes (Please List)

_____

_____

Dermatologist (if applicable):_____

Date of Last Dermatology Exam:_____

- **If you are new to our practice, how did you hear about us?**

- ☐ Friends/Family
- ☐ Google Search / Website
- ☐ Employee Recommendation
- ☐ Social Media
- ☐ Returning patient
- ☐ Doctor Referral

- **Please mark any previous cosmetic procedures you may have had (mark all that apply):**

- ☐ Fillers
- ☐ Neurotoxins (Dysport/Botox)
- ☐ Sculptra
- ☐ Laser Facials / rejuvenation
- ☐ Microneedling
- ☐ Body Contouring
- ☐ Skin tightening
- ☐ Other:_____
- ☐ Cosmetic Surgery(s), please list:

_____

_____

- **Do you have a history of (mark all that apply):**

- ☐ Skin Cancer
- ☐ Acne
- ☐ Alopecia
- ☐ Dysphagia (or trouble swallowing)
- ☐ Ear pain
- ☐ Jaw pain
- ☐ Bell's Palsy
- ☐ Headaches
- ☐ Migraines
- ☐ Using Accutane
- ☐ Bleeding and/or bruising easily
- ☐ Other:_____
- ☐ Family history of Skin Cancer, If yes, Relationship:_____

- **I am interested in:**

- ☐ Non-invasive cosmetic treatments
- ☐ Minimally invasive cosmetic procedures
- ☐ Surgical cosmetic procedures
- ☐ I am open to discussing all types of procedures

- **Please tell us specifically what you are interested in (mark all that apply):**

- ☐ Eyelid Surgery
- ☐ Brow Surgery
- ☐ Lip Augmentation
- ☐ Ear Lobe Repair
- ☐ Wrinkle Relaxers (Dysport/Botox)
- ☐ Volume Loss Correction (Fillers):
  - ☐ Face
  - ☐ Lips
  - ☐ Chin and/or Jawline
  - ☐ Hand Rejuvenation
  - ☐ Gluteal Augmentation
- ☐ Pigment / Redness Reduction (BBL/Photofacial)
- ☐ Laser Facials / Rejuvenation
- ☐ Chemical Peels
- ☐ Microneedling
- ☐ Laser Hair Removal
- ☐ Body Sculpting (CoolSculpting, EMSCULPT)
- ☐ B12 Injections
- ☐ Skin Care
- ☐ Platelet Rich Plasma (PRP)
- ☐ Laser Tattoo Removal
- ☐ Kybella (fat below the chin or submental fat)
- ☐ Skin Tightening (Ultherapy)
- ☐ Vein Removal/Reduction
- ☐ Other:_____

MEDICATIONS: ❑ See List ❑ None

_____

_____

_____

_____

_____

EMPIRE EYE & LASER CENTER

EMPIRE AESTHETIC CENTER

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name:_____ **Date of Birth**: _____

Address: _____

City:_____ **State:**_____ **Zip Code:**_____

☐ I have no individuals I want Empire Eye and Laser Center to discuss my PHI with at this time.

☐ I authorize Empire Eye and Laser Center (EELC) to discuss my PHI with the following individuals. This may include information about my appointments, diagnoses, and treatments.

Name:_____DOB:_____

Phone:_____Relationship:_____

Name:_____DOB:_____

Phone:_____Relationship:_____

This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless otherwise specified. I may revoke this authorization at any time by notifying EELC in writing. My revocation will not affect actions taken by EELC prior to its receipt.

I understand that once the information is disclosed, it may be re-disclosed by the recipient; federal and/or state privacy laws may or may not protect the re-disclosure. I understand that authorizing the disclosure of information identified above is voluntary, and this authorization is not intended to alter the patient's ability to receive medical care from any health care provider.

I have had the opportunity to read and to consider the contents of this authorization. I confirm that the contents are consistent with my direction.

_____	_____	_____
Patient/Authorized Signature	Printed Name (If not patient, indicate relationship)	Date