



## New Patient Registration

Date \_\_\_\_\_

Name \_\_\_\_\_  
Last First Middle

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex M / F / OTHER: \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_\_) \_\_\_\_\_

Cell Phone (\_\_\_\_\_) \_\_\_\_\_ E-Mail \_\_\_\_\_

**\*\* Would you like to subscribe to our monthly promotions e-newsletter? Y or N \*\***

Occupation \_\_\_\_\_ Employers Name \_\_\_\_\_

Marital Status: Single \_\_\_\_\_ Married \_\_\_\_\_ Widowed \_\_\_\_\_ Divorced \_\_\_\_\_ Separated \_\_\_\_\_

Name of Spouse (or parent if Minor) \_\_\_\_\_ Phone \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Family Doctor \_\_\_\_\_ Phone \_\_\_\_\_

Ophthalmologist or Optometrist \_\_\_\_\_ Phone \_\_\_\_\_

Cardiologist \_\_\_\_\_ Phone \_\_\_\_\_

Pharmacy & Phone \_\_\_\_\_  
Company Phone

How did you hear about us? Google \_\_\_\_\_ Yelp \_\_\_\_\_ Realself \_\_\_\_\_ Other \_\_\_\_\_

### Insurance information

Primary Insurance \_\_\_\_\_ ID#: \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ ID#: \_\_\_\_\_

Policy Holder's Name (if different from above) \_\_\_\_\_ DOB \_\_\_\_\_

SSN# \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Authorization: I hereby authorize Dr. Bradford Lee and associate to be the attending physician and to administer to me any examination, treatment, and medications he deems therapeutic to my presenting complaint. I hereby authorize Dr. Bradford Lee and associate to furnish information to my insurance carriers concerning this illness and I hereby irrevocably assign to the doctor all payments for medical services.

Signature of Patient/Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

## Patient History

Patient Name : \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Date of Last Dilated Eye Exam: \_\_\_\_\_

EYES	HEART	SKIN CONDITIONS
<input type="checkbox"/> Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Soft <input type="checkbox"/> Hard <input type="checkbox"/> Glaucoma <input type="checkbox"/> Dry Eye <input type="checkbox"/> Punctal Plugs <input type="checkbox"/> Cataracts <input type="checkbox"/> Strabismus <input type="checkbox"/> Macular Degeneration <input type="checkbox"/> Recent Fillers and/or Botox Location: _____  <input type="checkbox"/> Facial Trauma - Type: _____  <input type="checkbox"/> Thyroid Eye Disease <input type="checkbox"/> Oculopharyngeal Muscular Dystrophy <input type="checkbox"/> Ocular Cicatricial Pemphigoid (OCP) <input type="checkbox"/> Previous Eye, Eyelid, and / or Tearing Surgery – Type: _____ _____ _____	<input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Angina <input type="checkbox"/> Chest Pain <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Bypass <input type="checkbox"/> Stents <input type="checkbox"/> Mitral Valve Prolapse <input type="checkbox"/> Heart Murmur <input type="checkbox"/> Arrhythmia <input type="checkbox"/> Atrial-fibrillation <input type="checkbox"/> SVT <input type="checkbox"/> Heart Attack <input type="checkbox"/> Pacemaker <input type="checkbox"/> Defibrillator <input type="checkbox"/> Heart Transplant <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Wolff-Parkinson – White Syndrome	<input type="checkbox"/> Skin Cancer Type & Location: _____  <input type="checkbox"/> Rosacea <input type="checkbox"/> Eczema <input type="checkbox"/> Psoriasis
		RENAL
		<input type="checkbox"/> Bladder Disease <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Dialysis <input type="checkbox"/> Kidney Removal
		STOMACH
		<input type="checkbox"/> Hiatal Hernia <input type="checkbox"/> GERD <input type="checkbox"/> Diverticulitis <input type="checkbox"/> Ulcers
EARS, NOSE & THROAT		MUSCULOSKELETAL
<input type="checkbox"/> Limited Mouth / Neck Motion <input type="checkbox"/> TMJ History <input type="checkbox"/> Dentures <input type="checkbox"/> Ringing in Ears <input type="checkbox"/> Deviated Septum <input type="checkbox"/> Chronic Sinus Infections <input type="checkbox"/> Previous Sinus Surgery	<input type="checkbox"/> Anemia <input type="checkbox"/> Sickle Cell Anemia <input type="checkbox"/> Hepatitis <input type="checkbox"/> Leukemia <input type="checkbox"/> HIV <input type="checkbox"/> AIDS <input type="checkbox"/> Factor 5 Deficiency	<input type="checkbox"/> Back Pain <input type="checkbox"/> Arthritis <input type="checkbox"/> Trauma and / or Surgery to Neck or Shoulder – Type: _____ _____
ENDOCRINE	NEURO / PSYCHIATRIC	RESPIRATORY SYSTEM
<input type="checkbox"/> Diabetes - # of Years: _____ <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> Insulin Dependent <input type="checkbox"/> Non-Insulin <input type="checkbox"/> Diet Controlled <input type="checkbox"/> Hyperthyroid <input type="checkbox"/> Hypothyroid	<input type="checkbox"/> Stroke <input type="checkbox"/> Fainting Spells <input type="checkbox"/> Numbness <input type="checkbox"/> Myasthenia Gravis <input type="checkbox"/> Seizures <input type="checkbox"/> Bell's Palsy <input type="checkbox"/> Facial Paralysis <input type="checkbox"/> Headaches <input type="checkbox"/> Migraines <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety	<input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> COPD <input type="checkbox"/> Emphysema <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> CPAP <input type="checkbox"/> Sarcoidosis

### MEDICATION LIST

\_\_\_\_\_  
 \_\_\_\_\_

ALLERGIES	
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☐ Egg      ☐ Latex      ☐ Betadine      ☐ Penicillin      ☐ Sulfa

Please list any other allergies: \_\_\_\_\_

<b>SOCIAL HISTORY</b>
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Current Smoker ☐ Yes ☐ No If yes, how long: \_\_\_\_\_ How much: \_\_\_\_\_

Previous Smoker ☐ Yes ☐ No If yes, how long: \_\_\_\_\_ Date quit: \_\_\_\_\_

Alcohol ☐ Yes ☐ No If yes, frequency: \_\_\_\_\_

Drug Use ☐ Yes ☐ No If yes, type: \_\_\_\_\_

Occupation: \_\_\_\_\_

PREVIOUS SURGERIES	
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Any problems with anesthesia in the past? ☐ Yes ☐ No If yes, what: \_\_\_\_\_

Any personal history of cancer? ☐ Yes ☐ No If yes, what type: \_\_\_\_\_

<b>FAMILY HISTORY</b>
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☐ Thyroid Disease      ☐ Heart Disease      ☐ Diabetes      ☐ Cancer      ☐ Skin Cancer

CURRENT SYMPTOMS OR PROBLEMS YOU ARE HAVING	
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79	80
81	82
83	84
85	86
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91	92
93	94
95	96
97	98
99	100

	<u>Yes</u>	<u>No</u>
1. The respondent has been convicted of a crime involving moral turpitude.		
2. The respondent has been convicted of a crime involving dishonesty or fraud.		
3. The respondent has been convicted of a crime involving violence.		
4. The respondent has been convicted of a crime involving sexual conduct.		
5. The respondent has been convicted of a crime involving drug offenses.		
6. The respondent has been convicted of a crime involving alcohol offenses.		
7. The respondent has been convicted of a crime involving domestic violence.		
8. The respondent has been convicted of a crime involving child abuse or neglect.		
9. The respondent has been convicted of a crime involving terrorism or espionage.		
10. The respondent has been convicted of a crime involving organized crime.		
11. The respondent has been convicted of a crime involving racketeering.		
12. The respondent has been convicted of a crime involving money laundering.		
13. The respondent has been convicted of a crime involving firearms offenses.		
14. The respondent has been convicted of a crime involving explosives offenses.		
15. The respondent has been convicted of a crime involving nuclear material offenses.		
16. The respondent has been convicted of a crime involving biological weapons offenses.		
17. The respondent has been convicted of a crime involving chemical weapons offenses.		
18. The respondent has been convicted of a crime involving radiological weapons offenses.		
19. The respondent has been convicted of a crime involving cyber offenses.		
20. The respondent has been convicted of a crime involving intellectual property offenses.		
21. The respondent has been convicted of a crime involving environmental offenses.		
22. The respondent has been convicted of a crime involving labor law violations.		
23. The respondent has been convicted of a crime involving consumer protection violations.		
24. The respondent has been convicted of a crime involving securities law violations.		
25. The respondent has been convicted of a crime involving banking law violations.		
26. The respondent has been convicted of a crime involving insurance law violations.		
27. The respondent has been convicted of a crime involving tax law violations.		
28. The respondent has been convicted of a crime involving bankruptcy law violations.		
29. The respondent has been convicted of a crime involving contract law violations.		
30. The respondent has been convicted of a crime involving tort law violations.		
31. The respondent has been convicted of a crime involving property law violations.		
32. The respondent has been convicted of a crime involving family law violations.		
33. The respondent has been convicted of a crime involving probate law violations.		
34. The respondent has been convicted of a crime involving estate planning violations.		
35. The respondent has been convicted of a crime involving will contests.		
36. The respondent has been convicted of a crime involving trusts and trustees.		
37. The respondent has been convicted of a crime involving guardianship.		
38. The respondent has been convicted of a crime involving conservatorship.		
39. The respondent has been convicted of a crime involving powers of attorney.		
40. The respondent has been convicted of a crime involving health care directives.		
41. The respondent has been convicted of a crime involving end-of-life decisions.		
42. The respondent has been convicted of a crime involving assisted suicide.		
43. The respondent has been convicted of a crime involving euthanasia.		
44. The respondent has been convicted of a crime involving organ donation.		
45. The respondent has been convicted of a crime involving medical malpractice.		
46. The respondent has been convicted of a crime involving nursing home abuse.		
47. The respondent has been convicted of a crime involving elder financial abuse.		
48. The respondent has been convicted of a crime involving elder physical abuse.		
49. The respondent has been convicted of a crime involving elder psychological abuse.		
50. The respondent has been convicted of a crime involving elder neglect.		
51. The respondent has been convicted of a crime involving elder exploitation.		
52. The respondent has been convicted of a crime involving elder abandonment.		
53. The respondent has been convicted of a crime involving elder isolation.		
54. The respondent has been convicted of a crime involving elder harassment.		
55. The respondent has been convicted of a crime involving elder intimidation.		
56. The respondent has been convicted of a crime involving elder coercion.		
57. The respondent has been convicted of a crime involving elder manipulation.		
58. The respondent has been convicted of a crime involving elder deception.		
59. The respondent has been convicted of a crime involving elder fraud.		
60. The respondent has been convicted of a crime involving elder identity theft.		
61. The respondent has been convicted of a crime involving elder impersonation.		
62. The respondent has been convicted of a crime involving elder forgery.		
63. The respondent has been convicted of a crime involving elder signature theft.		
64. The respondent has been convicted of a crime involving elder document theft.		
65. The respondent has been convicted of a crime involving elder record theft.		
66. The respondent has been convicted of a crime involving elder information theft.		
67. The respondent has been convicted of a crime involving elder communication interception.		
68. The respondent has been convicted of a crime involving elder surveillance.		
69. The respondent has been convicted of a crime involving elder stalking.		
70. The respondent has been convicted of a crime involving elder harassment.		
71. The respondent has been convicted of a crime involving elder threats.		
72. The respondent has been convicted of a crime involving elder assault.		
73. The respondent has been convicted of a crime involving elder battery.		
74. The respondent has been convicted of a crime involving elder sexual assault.		
75. The respondent has been convicted of a crime involving elder sexual battery.		
76. The respondent has been convicted of a crime involving elder sexual harassment.		
77. The respondent has been convicted of a crime involving elder sexual exploitation.		
78. The respondent has been convicted of a crime involving elder sexual abuse.		
79. The respondent has been convicted of a crime involving elder sexual neglect.		
80. The respondent has been convicted of a crime involving elder sexual isolation.		
81. The respondent has been convicted of a crime involving elder sexual harassment.		
82. The respondent has been convicted of a crime involving elder sexual intimidation.		
83. The respondent has been convicted of a crime involving elder sexual coercion.		
84. The respondent has been convicted of a crime involving elder sexual manipulation.		
85. The respondent has been convicted of a crime involving elder sexual deception.		
86. The respondent has been convicted of a crime involving elder sexual fraud.		
87. The respondent has been convicted of a crime involving elder sexual identity theft.		
88. The respondent has been convicted of a crime involving elder sexual impersonation.		
89. The respondent has been convicted of a crime involving elder sexual forgery.		
90. The respondent has been convicted of a crime involving elder sexual signature theft.		
91. The respondent has been convicted of a crime involving elder sexual document theft.		
92. The respondent has been convicted of a crime involving elder sexual record theft.		
93. The respondent has been convicted of a crime involving elder sexual information theft.		
94. The respondent has been convicted of a crime involving elder sexual communication interception.		
95. The respondent has been convicted of a crime involving elder sexual surveillance.		
96. The respondent has been convicted of a crime involving elder sexual stalking.		
97. The respondent has been convicted of a crime involving elder sexual harassment.		
98. The respondent has been convicted of a crime involving elder sexual threats.		
99. The respondent has been convicted of a crime involving elder sexual assault.		
100. The respondent has been convicted of a crime involving elder sexual battery.		

- ☐ ☐ Fatigue
- ☐ ☐ Fever
- ☐ ☐ Night Sweats
- ☐ ☐ Increased Sweating
- ☐ ☐ Difficulty Sleeping
- ☐ ☐ Diplopia
- ☐ ☐ Blurred Vision
- ☐ ☐ Eye Pain
- ☐ ☐ Dry Eye
- ☐ ☐ Eyelid Drooping
- ☐ ☐ Visual Impairment
- ☐ ☐ Excessive Tearing
- ☐ ☐ Itching of Eyes
- ☐ ☐ Hearing Loss
- ☐ ☐ Difficulty Swallowing
- ☐ ☐ Ringing in Ear
- ☐ ☐ Sinus Pressure
- ☐ ☐ Runny Nose
- ☐ ☐ Chest Pain
- ☐ ☐ Palpitations

	<u>Yes</u>	<u>No</u>
1. The company has a policy on the use of social media.		
2. The company has a policy on the use of mobile devices.		
3. The company has a policy on the use of email.		
4. The company has a policy on the use of instant messaging.		
5. The company has a policy on the use of video conferencing.		
6. The company has a policy on the use of cloud storage.		
7. The company has a policy on the use of virtual reality.		
8. The company has a policy on the use of artificial intelligence.		
9. The company has a policy on the use of blockchain.		
10. The company has a policy on the use of quantum computing.		

- ☐ ☐ Rapid Heart Beat
- ☐ ☐ Irregular Heart Beat
- ☐ ☐ Shortness of Breath
- ☐ ☐ Wheezing
- ☐ ☐ Cough
- ☐ ☐ Nausea
- ☐ ☐ Vomiting
- ☐ ☐ Jaundice
- ☐ ☐ Reflux / Heartburn
- ☐ ☐ Blood in Urine
- ☐ ☐ Difficulty with Urination
- ☐ ☐ Increased Urination
- ☐ ☐ Skin Rash
- ☐ ☐ Skin Lesion
- ☐ ☐ Hives or Eczema
- ☐ ☐ Joint Pain
- ☐ ☐ Joint Swelling
- ☐ ☐ Back Pain
- ☐ ☐ Seizure
- ☐ ☐ Dizziness

<b>Yes</b>	<b>No</b>
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- ☐ ☐ Facial Spasms
- ☐ ☐ Weakness
- ☐ ☐ Paralysis
- ☐ ☐ Numbness
- ☐ ☐ Tremor
- ☐ ☐ Vertigo
- ☐ ☐ Headaches
- ☐ ☐ Bruising Tendency
- ☐ ☐ Bleeding Tendency
- ☐ ☐ Anticoagulant Therapy -  
(Blood Thinners)
- ☐ ☐ Weight Loss
- ☐ ☐ Weight Gain
- ☐ ☐ Heat and/or Cold Intolerance
- ☐ ☐ Increased Thirst
- ☐ ☐ Depression
- ☐ ☐ Anxiety
- ☐ ☐ Mood Swings
- ☐ ☐ Stress

Are you up to date on these vaccines? \_\_\_ Influenza \_\_\_ Pneumonia \_\_\_ Other: \_\_\_\_\_

Completed by:    ☐ Patient        ☐ Family Member (Read and Reviewed with the Patient)

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_



# OCULOFACIAL PLASTIC SURGERY *of* HAWAII

## CONSENT FOR PHOTOGRAPHY

I authorize Dr. Bradford Lee and Oculofacial Plastic Surgery of Hawaii, Inc. to take photographs, audio recordings and/or video recordings of me/(my child) for the purposes of medical documentation, insurance authorizations, and as part of my clinical care by Dr. Lee, his staff and associates, and other consulting physicians involved in my care.

Patient Initials: \_\_\_\_

Dr. Lee is involved in teaching other physicians, patient education, research, and practice marketing activities for which before and after photos, procedural videos, and associated clinical case information can be invaluable. I authorize Oculofacial Plastic Surgery of Hawaii, Inc. and Dr. Lee to use my medical records, include photographs, videos, and clinical information for use in:

Please circle which we may use: **Full face photos** and/or **Cropped photos of eyes only**

Patient Initials: Yes\_\_\_\_ No\_\_\_\_ Medical training, teaching, scientific meetings, and medical journals or books

Patient Initials: Yes\_\_\_\_ No\_\_\_\_ Publications of any media format, including magazines, online internet media, broadcast, social media (e.g. Facebook, Instagram, Twitter, YouTube), websites, or for other promotional, advertising, or commercial purposes.

I hereby grant and release all claims, rights, and interests that I might have in such photography or audio or video recordings or use thereof. I agree that Oculofacial Plastic Surgery of Hawaii, Inc. and its employees will not be responsible for any claims arising in any way out of the taking and use as described above of such photographs, recordings, and case histories. I understand that I will not have an opportunity to inspect and approve such photographs or recordings prior to their use, and that Oculofacial Plastic Surgery of Hawaii, Inc. will be the owner of such photographs and/or recordings.

PATIENT/PARENT/GUARDIAN NAME (PRINTED):\_\_\_\_\_ DATE:\_\_\_\_\_

PATIENT/PARENT/GUARDIAN SIGNATURE: \_\_\_\_\_



## Notice of Privacy Practices

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to my privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly .
- Obtain payment from third party payers
- Conduct normal healthcare operations such as quality assessments and physicians certifications

I acknowledge that I can request and review your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at anytime at the address above to obtain the current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then are bound to abide by such restrictions.

### Authorization for Disclosure of Treatment

I understand that Oculofacial Plastic Surgery of Hawaii maintains my personal records, medical history, symptoms, examinations, and test results as a part of my healthcare. This information is not to be given to any other person without my permission. Therefore, this is a written consent to authorize release of my medical information.

### **Release of Information**

I authorize the release of information including the diagnosis, laboratory values, prescribed medications, treatment plan, examination rendered and claim information. This information may be released to:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Please check if Information is NOT to be released to anyone \_\_\_\_\_

Please check if okay to leave detailed information on voicemail \_\_\_\_\_

**Patient Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



## Financial Policy

### Insurance

Our office participates with most insurance plans. Please contact your insurance regarding specific coverages and benefits. We require a copy of your updated insurance card and a valid ID at the time of your appointment. Certain insurances require a referral from your primary care provider (PCP) to provide coverage for your visit. Please contact your PCP's office if you require a referral, prior to each service rendered.

Some insurance plans will cover the total cost of your office visit and/or surgery; other plans will only cover part of it. It is the patient's responsibility to be informed of their insurance benefits including deductibles, copayments, and co-insurances. Please call the phone number on the back of your insurance card if you have questions. You are responsible for paying all charges not covered by your insurance at the completion of your visit.

### Cosmetic Consultation

There is a \$200 non-refundable consultation fee that covers a full consultation with Dr. Bradford Lee or one of his physician assistants. You will also meet with the surgical coordinator who will provide detailed information on surgical options/ quotes and information regarding pre/ post operative instructions. This fee applies to both in-person and telemedicine consultations. If a procedure is scheduled, the consultation fee is applied towards the cost of the procedure.

### Surgery Fees

We perform surgical procedures in our Ambulatory Surgical Center (ASC) or in our in-office surgical suites. Surgical claims submitted to your insurance may include the surgeon's fee, a facility fee, and/or the anesthesiology fee. For cosmetic surgeries, a 20% non-refundable deposit is collected at the time of scheduling, and the remaining balance is due 30 days prior to your surgery date.

### Payment

We accept cash, check, or credit card. Returned checks are subject to a \$35 service fee. Credit card charges over \$1000 for any non-surgical/ cosmetic procedures or cosmetic products will be subject to a 3% credit card fee. To avoid this fee, please pay by cash or check.

### Cancellation Policy

Please call our office if you cannot make it to your appointment/ surgery. Cancellations made within 24 hours of your appointment may result in a \$150 cancellation fee. No refunds will be provided for surgeries cancelled within 30 days of your scheduled surgery date. NO refunds can be issued for completed procedures, cosmetic consultation fees, and cosmetic products.

### PATIENT FINANCIAL OBLIGATION AGREEMENT:

I understand that all applicable copayments, deductibles, and cosmetic fees are due at the time of service. I agree to be financially responsible and provide payment for charges not covered by my insurance company. I authorize my insurance benefits to be paid directly to Oculofacial Plastic Surgery of Hawaii Inc. for services rendered. I authorize representatives of Oculofacial Plastic Surgery of Hawaii Inc. to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim.

### FINANCIAL POLICY/ NOTICE OF PRIVACY PRACTICES:

I acknowledge that I was provided a copy of the Oculofacial Plastic Surgery of Hawaii Inc. Financial Policy and Notice of Privacy Practices.

**BY SIGNING BELOW, I ACKNOWLEDGE I HAVE READ, UNDERSTAND, AND AGREE WITH THE FINANCIAL POLICY, AND NOTICE OF PRIVACY PRACTICES.**

Patient Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_