Kimberly K. Lu, MD
Plastic and Reconstructive Surgery

PT. NAME _____ M ___ F ___ DOB _____ AGE _____
Last First MI
SS# _____
ADDRESS _____ YOUR OCCUPATION _____
CITY/STATE _____ ZIP _____ YOUR EMPLOYER _____
HOME PHONE ( ) _____ SPOUSE'S DOB _____
WORK PHONE ( ) _____ SPOUSES OCCUPATION _____
CELL PHONE ( ) _____ SPOUSES EMPLOYER _____
REFERRED BY **PRIMARY CARE PHYSICIAN**

PRIMARY INSURANCE _____ **SECONDARY INSURANCE** _____
Insured _____ DOB _____ Insured _____ DOB _____
Employer _____ Employer _____
Relationship to patient _____ Relationship to patient _____
Insured ID No. _____ Insured ID No. _____
Group No. _____ Group No. _____

Does your insurance require preauthorization before hospitalization or procedures? ☐ YES ☐ NO
If YES, phone number to call:

BILLING: If person responsible for bill is **other than above patient**, please complete.

NAME _____ SS# _____
Last First MI
OCCUPATION _____
Relationship to patient _____ EMPLOYER _____
ADDRESS _____ ADDRESS _____
CITY/STATE _____ ZIP _____ CITY/STATE _____ ZIP _____
HOME PHONE ( ) _____ WORK PHONE ( ) _____

EMERGENCY INFORMATION: Person to contact in case of emergency, not living at the above address.
NAME _____ PHONE _____

Please read the following statement carefully before signing.

1. I authorize treatment of the person named above and agree to pay all fees for such treatment.
2. I hereby authorize the clinic to receive all benefits to which my dependents or I are entitled to under my health insurance plan. In addition, I will not withhold or delay payment if my insurance company denies payment on any of my charges. I acknowledge there is a **$35.00 fee on checks returned from my bank.** Should the balance of the account exceed an amount the undersigned is able to pay in full, an agreed payment plan can be established with **1% interest per month** on the unpaid balance.
3. I authorize Kimberly K. Lu, MD and her agents to release any medical information acquired in the course of my examination or treatment to process my insurance claims.

SIGNATURE _____ RELATIONSHIP TO PATIENT _____
DATE _____

MEDICAL INFORMATION

PATIENT NAME: _____

REASON FOR OFFICE VISIT TODAY (PLEASE BE SPECIFIC)_____

_____

REFERRED BY (NAME OF PHYSICIAN OR FRIEND_____

IF INJURED, DATE OF INJURY_____DID THIS OCCUR AT WORK?_____

HAVE YOU SEEN DR. LU BEFORE?_____

IF SO, WHEN?_____

NAME OF USUAL PHYSICIAN_____

PAST
SURGERY_____

_____

KNOWN MEDICAL PROBLEMS (IF NONE , WRITE NONE) _____

_____

_____

DO YOU SMOKE CIGARETTES OR USE TOBACCO PRODUCTS? YES( ) NO( )

HAVE YOU BEEN TESTED FOR THE HIV (AIDS) VIRUS? YES( ) NO( )

RESULTS_____DATE OF TEST_____
TO YOUR KNOWLEDGE HAVE YOU BEEN EXPOSED TO HIV? YES( ) NO( )

PATIENT NAME_____

DATE_____

Medication ALLERGIES: please check
_____ I have no medication allergies
_____ I have medication allergies. Please list and describe what happens:

_____

_____

_____

_____

What medications do you take? (include aspirin, non prescription medications, vitamins and natural pathic medications)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____

Other:

Assignment and Release

I hereby irrevocably authorize my insurance company/fund to pay benefits for services directly to Kimberly K. Lu, M.D. if I have not paid in full myself. Furthermore, I understand **that I am financially responsible for any amount not paid by my insurance company**. I also authorize Dr. Lu to release any information required to process a claim, including but not limited to insurance companies, health care service plans, worker's compensation carriers and government services.

I understand that the office will submit charges to my insurance carrier and that there is a requirement that my portion be paid on the day treatment is rendered. I understand that if I do not have insurance coverage, payment is due in full for any professional services and supplies. Regardless of pending insurance claims, all accounts are to be finalized within 60 days.

By signing below, I indicate that I have read and understand the above information and release insurance benefits to be paid to Kimberly K. Lu, M.D.

Patient's Signature _____ Date _____

If Patient is a minor:
Parent or Guardian's Signature _____ Date _____

Relationship to minor: _____

Privacy

I understand that the Federal Government has placed restrictions on the exchange/release of patient medical information. In cooperation with these new regulations and to facilitate better and more rapid exchange of information, I offer consent to the release of information to other treating physicians or health care providers, hospitals, my insurance company (or other payers). I understand this information may be exchanged via mail, fax, other electronic media (e-mail), telephone or orally. **All attempts will be made to keep this information STRICTLY confidential.**

I have been informed of my medical provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my provider has the right to change the *Notice of Privacy Practices* and that I may contact the office to obtain a 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 and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient's Signature _____ Date _____

If Patient is a minor:
Parent or Guardian's Signature _____ Date _____

Relationship to minor: _____

Witness: _____ Date _____