Timothy F. McDevitt MD, Inc.
The Oculoplastics Center
1380 Lusitana Street, Suite 708, Honolulu, HI 96813

PT. NAME ______________________ (Last / First / MI) M ___ F ___ DOB ____________ AGE ______
SOCIAL SECURITY # ______________________
MAILING ADDRESS ______________________ YOUR OCCUPATION ______________________
CITY/STATE ______________________ YOUR EMPLOYER ______________________
PHYSICAL ADDRESS ____________ ZIP ______ SPOUSE'S NAME ______________ DOB ________
CITY/STATE ______________________ SPOUSES OCCUPATION ______________________
MAILING AND PHYSICIAL ADDRESS THE SAME ☐ SPOUSES EMPLOYER ______________________
HOME PHONE ( ) ______________________ CELL PHONE ( ) ______________________
WORK PHONE ( ) EMAIL

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 ______________________ (Last / First / MI) SS# ______________________
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 ____________ RELATIONSHIP ____________

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 Dr. McDevitt and their agents to release any medical information acquired in the course of my examination or treatment to process my insurance claims.
4. I have read and agree to the terms listed on the form, "NOTICE OF PRIVACY POLICIES FOR THE OCULOPLASTICS CENTER".

SIGNATURE ______________________ RELATIONSHIP TO PATIENT ______________________
DATE ______________________

The Oculoplastics Center
Cosmetic & Reconstructive Surgery of the Eyelid, Lacrimal System and Orbit

Timothy F. McDevitt, M.D.
Queens Physician's Office Building 1
1380 Lusitana Street, Suite 708
Honolulu, HI 96813

Medical History

Name: ______________________ Date: ____________

Who referred you here today?
Name: ______________________
Address: ______________________
Telephone: ______________________

Reason(s) for visit: ______________________
How long has it been present? ______________________
How often does it happen: ______________________
What treatment(s) have you had before? ______________________

What medical problem are you being treated for? Who are your doctors?

Doctor:	Illness/Condition:	Phone

Have you had any surgeries in the past? Who was/were the surgeons?

Doctor:	Surgery:	Phone:

Do you have a pacemaker? _______yes _______No If "yes", what type? ______________________

What medications do you take? (Pills, ointments, vitamins, eye drops) ______________________

Do you take aspirin containing products/medications? _______yes _______No

Allergies: _______None _______Penicillin _______Sulfa _______Fluorecein _______Idoine dyes _______Shellfish _______Latex
_______Other (Please list) ______________________

Past Medical History: Please check any problem you have had and explain. If you have not had any problems, check "no".

General (constitutional)

Yes	No	
____	____	weight loss ____________
____	____	lack of energy ____________
____	____	trouble sleeping ____________
____	____	problems with anesthesia ____________

Eyes

Yes	No	
____	____	vision loss ____________
____	____	any change in vision ____________
____	____	eye pain ____________
____	____	dry eye ____________
____	____	other ____________

Ears, Nose, Mouth, Throat

Yes	No	
____	____	hearing loss ____________
____	____	sinus problems ____________
____	____	infections ____________
____	____	other ____________

Lungs (respiratory)

Yes	No	
____	____	asthma ____________
____	____	bronchitis ____________
____	____	shortness of breath ____________
____	____	tuberculosis (TB) ____________
____	____	other ____________

Stomach & Intestines (gastrointestinal)

Yes	No	
____	____	ulcers ____________
____	____	diverticulitis ____________
____	____	constipation ____________
____	____	hepatitis ____________
____	____	other ____________

Kidneys, Bladder, Prostate, (genitourinary)

Yes	No	
____	____	kidney infections ____________
____	____	urinary infections ____________
____	____	cancer ____________
____	____	other ____________

Heart & Blood Vessels

Yes No

____ ____ heart attack ____________________

____ ____ high blood pressure ____________________

____ ____ how long? ____________________

____ ____ last check? ____________________

____ ____ heart murmur ____________________

____ ____ irregular heart beat ____________________

____ ____ mitral valve prolapsed ____________________

____ ____ chest pain ____________________

____ ____ circulation problems ____________________

____ ____ other ____________________

Nervous system & Brain

Yes No

____ ____ seizure ____________________

____ ____ stroke ____________________

____ ____ paralysis/weakness ____________________

____ ____ numbness ____________________

____ ____ other ____________________

Mental Illness (psychiatric)

Yes No

____ ____ depression ____________________

____ ____ chemical imbalance ____________________

____ ____ mania, bipolar ____________________

____ ____ schizophrenia ____________________

____ ____ other ____________________

Endocrine System

Yes No

____ ____ diabetes ____________________

____ ____ thyroid condition ____________________

____ ____ other ____________________

Bones, Respiratory, Mus(Musculoskeletal)

Yes No

____ ____ osteoporosis ____________________

____ ____ arthritis ____________________

____ ____ muscle pain ____________________

____ ____ other ____________________

Skin/Breast (Integumentary)

Yes No

____ ____ Keloid scarring ____________________

____ ____ rashes, sensitivities ____________________

____ ____ skin cancer ____________________

____ ____ breast cancer ____________________

____ ____ other ____________________

Blood (hematoiologic/lymphatic)

Yes No

____ ____ anemia (low blood count) ____________________

____ ____ excessive bleeding ____________________

____ ____ clotting problems ____________________

____ ____ other ____________________

Allergic/Immunologic

Yes No

____ ____ lupus ____________________

____ ____ arthritis ____________________

____ ____ HIV ____________________

____ ____ other ____________________

Social History

What is your occupation? ____________________ Are you still working? ____________________

Do you still smoke cigarettes? ______ If "yes", how may per day? __________ For how many years? ____________________

Do you drink alcohol? __________ If "yes", how much? __________ For how many years? ____________________

Do you exercise? __________ If "yes", what kind? __________ How often? ____________________

Have you ever lived outside of Hawaii? ______ If "yes", where? __________ How long? ____________________

Past and present drug use (legal and illegal) is important for drug and anesthetic interactions. Please indicated if we need to be aware of any drug use ______ yes ______ no

Have you had a blood transfusion since 1977? ____________________

Family Medical History: Has any member of your family (father, mother, father's parents, mother's parents, brothers, sisters) had any of the following medical problems? Please check "yes" or "no" and list which member of your family (write down "mother" of "brother", etc.) had the problem in the space provided.

Yes No

____ ____ diabetes ____________________

____ ____ thyroid disease ____________________

____ ____ stroke ____________________

____ ____ anemia ____________________

____ ____ hepatitis ____________________

____ ____ cancer ____________________

Type ____________________

____ ____ glaucoma. ____________________

Yes No

____ ____ tuberculosis ____________________

____ ____ heart disease ____________________

____ ____ high blood pressure ____________________

____ ____ kidney disease ____________________

____ ____ bleeding disorder ____________________

____ ____ problems with anesthesia ____________________

____ ____ I do not know my family history ____________________

Is there anything not mentioned on this form you would like Dr. Timothy McDevitt to know?

____

Signature: ______________________________ Date: ____________________

Timothy F. McDevitt, MD
Queen's POB I
1380 Lusitana Street, Suite 708 • Honolulu, HI 96813
Phone: (808) 599-4755 • **Fax**: (808) 599-5397 • **E-Mail**: eyelids@oculoplasticscenter.com
Website: www.oculoplasticscenter.com

FINANCIAL POLICY

Thank you for the opportunity to serve you. We are committed to providing you with the very best care possible. The following is a statement of our financial policy that outlines patient and office financial responsibilities. Please contact our billing department at 1-425-228-5228, located at PO Box 50150 Bellevue, WA 98015, if you have any questions. Feel free to inquire with our office for their toll free number.

PATIENT PAYMENTS

We accept cash, checks, Visa, and MasterCard for all payments that are due on your account. Payment is due at the time of service.

ALL INSURANCE CARRIERS

Claims will be filed with your insurance company. You will be responsible at the time of service for all co-pays, co-insurance, deductibles, and services not covered by your plan. Financial responsibility for services rendered rests with the patient regardless of any insurance coverage. Although we will do everything possible to facilitate reimbursement from your insurance company, we cannot guarantee payment of your claim

HMO'S

The patient is responsible for obtaining valid referrals for any and all covered services. If the patient chooses to undergo any service without a valid referral, the patient is financially responsible for the full charges. Any and all co-pays are due at the time of service.

SELF-PAY PATIENTS

Full payment is due at the time of service. For urgent surgery, payment in full is required prior to surgery.

CHANGE OF INSURANCE

It is your responsibility to provide our office with any insurance changes. If you have dual insurance, you must notify our office of this information and provide copies of both cards, at the time of your visit, to ensure proper billing.

STATEMENTS

Regardless of any claim pending, if there is an open balance a statement may be sent to you once a month. Any patient balances remaining **after your insurance has made payment,** must be fully paid within 30 days.

COLLECTIONS AND NSF CHECKS

Delinquent accounts will be forwarded to our collection agency. A **collection fee of $50** will be added to the unpaid balance to recover our costs for collection. In the event litigation is necessary, you will be liable for court costs and attorney fees as well. Our bank charges us whenever a patient presents a check that does not have funds available. As a result, we will charge you a **$35.00 fee**. All future visits will need to be paid by either cash or credit card.

SCHEDULING SURGERY

Surgery scheduling requires careful planning and coordination between our office, the surgery center and their operating room staff, as well as your anesthesiologist. To schedule surgery, you will be asked to pay your co-payment, co-insurance, or deductible amount for Dr. McDevitt's services, prior to surgery. This amount must be paid at least two weeks in advance of your surgery.

CANCELLATION POLICY FOR IN-OFFICE APPOINTMENTS

Please give us at least 24 *business hours* notification if you cannot keep an appointment. This courtesy will allow others to be seen. Any appointment cancelled less than 24 hours of the scheduled appointment time will be subject to a **$50.00 cancellation fee**. Patients who do not show up for scheduled appointments are also subject to a **$50.00 fee**. We do realize that emergencies arise; however, after ***two(2) Late Cancellations or No-Shows***, you will be sent a letter by mail that charges will be applied to your account.

CANCELLATION OF SURGERY

Any surgery that is cancelled or rescheduled **less** than 21 days before your scheduled surgery date, is subject to a **$100 fee**. If surgery is cancelled for reasons beyond your control, (i.e. a more serious medical problem), this fee will be waived.

CANCELLATION OF COSMETIC SURGERY/PROCEDURES

Full payment must be received two weeks prior to surgery/procedure. If surgery is cancelled less than 21 days prior to your surgery/procedure, 25% of the of the fee will be forfeited (only 75% will be refunded).

REFUNDS

All refunds will be processed within 6-8 weeks after the overpayment is discovered on a patient's account or at the time the refund is requested. Patients who have insurance but made a partial payment or made payment in full, will not be refunded until payment in full is received from their insurance company. When payment was made by cash or check, a refund will be issued in the form of a check. When payment was made by credit card, a refund will be issued back to *the same* card that was charged unless otherwise determined by management.

MEDICAL RECORDS

Your medical records are held with the strictest of confidence. If you request a copy of your records be sent to another physician or to yourself, a written authorization is required. Only the requested records will be forwarded. When bringing in another physician's records to us, you may want to consider keeping a copy for yourself.

FORM COMPLETION

Forms completed outside of an office visit may be subject to a fee, depending on complexity.

I hereby give my consent for Dr. Timothy F. McDevitt to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations. With this consent, Dr. Timothy F. McDevitt and staff may call my home or other alternative locations and leave a message on voicemail or in person in reference to any items that assist the office in carrying out treatment, payment, and healthcare operations, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory and/or pertinent results. Dr. Timothy F. McDevitt may mail to my home or other alternative locations any items that assist the office in carrying out treatment, payment, and healthcare operations, such as surgery packets and patient statements. By signing below, I acknowledge that I have read and understand the information presented above and wish to receive treatment and services from Dr. Timothy F. McDevitt. I agree to be fully responsible for any and all charges for services rendered.

We welcome the opportunity to answer any questions that you may have in regards to our financial policies. It is our goal to ensure that patients have the best experience possible during their visits to our office.

PRINT NAME ____________________ DATE OF BIRTH ________________

PATIENT SIGNATURE (OR PARENT/GUARDIAN) ____

DATE ________________________

I have provided the patient with this document and answered any questions that he/she had in regards to what is stated above. ____________________
Employee Initials/Date

Timothy F. McDevitt, MD, Inc. 2013