AESTHETIC EYE ASSOCIATES, PS
DBA: ALURE LASER CENTER & MEDISPA
FINANCIAL & INSURANCE POLICY

IDENTITY THEFT PROTECTION: I understand that by Washington State Identity Theft Protection I will be required to show valid picture identification. Valid identification must include the patient's picture and date of birth. Examples: A Washington Driver's License, Valid Passport, State Resident Identification Card, Work Permit or Green Card.

INSURANCE COMPANY REFERRALS: If your insurance carrier requires a referral, it will be the patient's responsibility to obtain that referral from their primary care physician. All services at Aesthetic Eye Associates, PS are considered medical in nature and are not part of your vision plan. If a referral is required and not obtained prior to your appointment, the patient will be responsible.

INSURANCE AUTHORIZATION: Many insurance carriers require that eyelid procedures be authorized prior to your surgical procedure. This requires a written letter of documentation, pre-operative photos and possible diagnostic procedures. This process takes on average 25 business days for the insurance carriers to process. Please keep in mind that insurance carriers do not give guarantees of payment. They only tell us if your case meets their medical criteria for coverage. Our office will handle this authorization process for you. **If you have not heard from our office regarding preliminary status within 10 working days following your consultation, please contact our office at 425-216-7200.**

DEDUCTIBLES AND CO-PAYMENTS: Co-Payments are due and payable at the time of your visit. We do not bill you for your co-payments. You may be responsible for covering your annual deductibles prior to an office procedure. Deductibles and Co-payments, by law, cannot be adjusted at the discretion of the surgeon or their office.

RETURNED CHECK POLICY: Patients will be responsible for a $35.00 Service Fee for any check returned to our office by your bank as not valid for payment.

BILLING SERVICE: All medical billing is performed by an outside billing source, which can be reached by calling 425-216-7280. The staff at Aesthetic Eye cannot assist you with billing questions and do not have access to your account. Aesthetic Eye Associates & Allure Laser Center accepts Mastercard & Visa. Payment arrangements can also be made through the billing service to assist you in any remaining balances indicated by your insurance carrier. Our billing service is available to assist you Monday through Thursday 8:00 a.m. to 4:00 p.m.

Cosmetic Services: Non-surgical cosmetic services must be paid in full at the time the service is rendered. All Cosmetic Surgery fees are payable and due 72 hours prior to the day of your surgery.

POST-OPERATIVE PERIOD: Most office procedures (such as but not limited to: chalazions, lump and bump removals, injections and some tear duct procedures) have a 10-day global surgical period. This means that all care that is directly related to your surgical office procedure is included in the initial surgical fee for the first 10-days following your procedure. Once this 10-day global period has passed, your future visits will be billed to your insurance company. **Exceptions** to this rule would be any care received that is not directly related to your surgical procedure (a different diagnosis) or a return to the operating room for more surgery. These exceptions will be billed to your insurance carrier for further payment. Any medical care provided after the 10-days will be submitted to your insurance carrier for reimbursement and you will be responsible for additional co-payments and any and all charges deemed by your insurance carrier to be the responsibility of the patient.

All major surgeries performed in our ambulatory surgery center have a 90-day global post-operative period and will follow the same protocol as the 10-day global period.

EXPECTATIONS: Insurance carriers will only cover the portions of surgical procedures that directly affect the functioning of the eye. They will not cover any procedure that is not related to the actual functioning of the eye and are strictly performed for the enhancement of appearance. You may discuss these types of appearance enhancements with your surgeon at the time of your consultation as they often can be performed at the same time as your insurance related procedure at a cost savings.

TOUCH UP PROCEDURES: While we strive to obtain the best surgical outcome, some patients may require a touch up procedure(s) to obtain their final result. These procedures generally happen 6 months to one year following the initial procedure. Some of these touch-up procedures may be deemed cosmetic by your insurance carrier and would be your personal financial responsibility.

GUARANTEES OF OUTCOME: There is no such thing as permanent or perfect surgery. Aesthetic Eye Associate's Surgeons cannot give or provide any guarantee to surgical outcome. Complications and Risks are outlined on our patient consent form and should be read carefully. If you should have any questions, please do not hesitate to discuss with your surgeon or their clinical staff.

PATIENT RIGHTS AND RESPONSIBILITIES: WASHINGTON STATE LAW GUARANTEES THAT YOU HAVE THE RIGHT AND OBLIGATION, AS A PATIENT, TO BE INFORMED ABOUT YOUR CONDITION AND THE RECOMMENDED SURGICAL, MEDICAL, OR DIAGNOSTIC PROCEDURE. WITH THIS INFORMATION YOU MAY MAKE THE INFORMED DECISION WHETHER OR NOT TO UNDERGO THE PROCEDURE AFTER KNOWING THE RISKS AND HAZARDS INVOLVED. THIS DISCLOSURE IS NOT MEANT TO SCARE OR ALARM YOU; IT IS SIMPLY AN EFFORT TO MAKE YOU BETTER INFORMED SO YOU MAY GIVE OR WITHHOLD YOUR CONSENT TO THE PROCEDURE

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AESTHETIC EYE ASSOCIATES
425-216-7200
(Please Print Legibly & Fill In or Correct All Fields)

Patient's Name _____
Last First Middle

Address _____
Street & Apt # City State Zip

Home Phone _____ Cell Phone _____ Work Phone _____

Preferred Contact Number: _____ Birthdate ___/___/____ SS# _____-___-_____ (*If required by insurance*)

Sex ❑F ❑M Marital Status: Single Married to: _____ Other _____

PARENT OR LEGAL GUARDIAN INFORMATION (*If Applicable*)		
Last Name	First	MI
Home Phone ( )	Work Phone ( )	

EMERGENCY CONTACT INFORMATION		
Last Name	First	MI
Preferred Contact Number ( )	Email Address	

DURABLE POWER OF ATTORNEY INFORMATION (*If applicable, we request to have a copy for our files*)			
Last Name	First		MI
Relationship	Preferred Contact Number ( )	Email Address	

REFERRING PHYSICIAN INFORMATION	
Name	Telephone ( )
Address	City, State, Zip

PRIMARY CARE INFORMATION	
Name	Telephone ( )
Address	City, State, Zip

PREFERRED PHARMACY INFORMATION	
Name	Telephone ( )
Address	City, State, Zip

Patient's Employer: _____ Occupation: _____

PRIMARY INSURANCE COMPANY INFORMATION

Primary Insurance Company Name	Identification Number			Group Number
Primary Insurance Company Address	City	State	Zip	Telephone ( )
Policyholder	❑ Male ❑ Female			Date of Birth (of Policy Holder)
Social Security Number *(of policyholder)*	Telephone *(of policyholder)* ( )			Relationship to Patient
Employer *(of policyholder)*				

SECONDARY INSURANCE COMPANY INFORMATION

Secondary Insurance Company Name	Identification Number			Group Number
Secondary Insurance Company Address	City	State	Zip	Telephone ( )
Policyholder	❑ Male ❑ Female			Date of Birth (of Policy Holder)
Social Security Number *(of policyholder)*	Telephone *(of policyholder)* ( )			Relationship to Patient
Employer *(of policyholder)*				

Your Healthcare Provider may need to contact you to discuss your health, review results of testing or to coordinate your care. Please review and answer a few questions regarding your preferences regarding this communication.

	NO	YES	N/A
1. May we communicate with you via **text** on your cellular telephone (privacy not protected)?	____	____	____
2. May we and our billing department communicate with you via your **email** (privacy not protected)?	____	____	____
If yes, what email may we use? _____			
3. May we include you on our mailing or email list for promotional information?	____	____	
4. Do you need an interpreter to help you communicate?	____	____	
If yes, what language?: _____			

5. May we call regarding appointment changes/confirmations?
   At Home? __NO __YES At Work? __NO __YES Cell Phone? __NO __YES
6. May we leave messages regarding your health on your answering machine or voice mail?
   At Home? __NO __YES At Work? __NO __YES Cell Phone? __NO __YES

7. **Is there anyone that you would like to have complete access both verbally and in writing to your medical information?**	NO	YES
	____	____

IF YES: Last Name: _____ First Name: _____ MI: _____
Preferred Contact Number: _____ Email Address: _____
Last Name: _____ First Name: _____ MI: _____
Preferred Contact Number: _____ Email Address: _____

I AGREE that I am making this request for my convenience, without coercion or pressure by my healthcare provider or any other party. I understand that this request may result in someone other than me learning of my personal health information. I also understand that this agreement will be in place until I personally request in writing that it be cancelled. I will be responsible for completing a new request form to update contact numbers should they change. If my contact numbers should change, I give permission to send test results to me by mail.

****

I have read and understand Aesthetic Eye Associates, DBA: Allure Laser Center & Medispa, financial and insurance policies.

Insurance Related Visit: I authorize my insurance benefits to be paid directly to the doctor. I understand and accept that I am financially responsible for any balance due as directed by my insurance carrier. I authorize the doctor or insurance company to release any information required for the claim

Cosmetic Related Visit: I understand that all Medispa and cosmetic services are payable in full on the day service is rendered. I understand these services will not be covered by my insurance company.

Patient print name: _____ **Date** _____

Signature _____ **Date** _____

Reviewed by patient: _____ Date _____

Reviewed by patient: _____ Date _____

AESTHETIC EYE ASSOCIATES

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

HIPAA

I understand that as part of my healthcare, this practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatments, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communicating among the many health professionals who contribute to my care
- A source of information for applying any diagnoses and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand I can be provided with a Notice of Privacy Practices that details a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change its notice and practices and, prior to implementation, will post the modified Notice in the main service locations and on our website at www.allurecosmeticsurgery.com. I understand that I have the right to request restriction as how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing to the main service location at Aesthetic Eye Associates, PS/DBA: Allure Laser Center & Medispa, 625 4th Avenue, Suite 301, Kirkland, WA 98033 except to the extent that the organization has already taken action in reliance on the consent.

I understand that I will be informed should my medical case be included in any investigational research, education or studies.

I have received a copy of my surgeon's medical credentials.

Please list any additional restrictions below: _____

_____

I fully understand and accept the terms of this consent.

Patient Name:			DOB:		
Patient Signature	Date	Time	Witness to Signature Only	Date	Time

PATIENT LABEL

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www.AllureCosmeticSurgery.com

ARE YOUR EYES AND EYELIDS AFFECTING THE THINGS YOU DO?

The doctor would like to know if you are noticing problems during your everyday activities because of your upper or lower eyelids. Please answer each question by rating the level you feel the concern is affecting your everyday life activities.

1. **Do your eyes or eyelids feel irritated and itchy?** **NONE MILD MODERATE SEVERE**
   Clinic Use_____

2. **Do your eyelids fatigue with effort to keep them open?** **NONE MILD MODERATE SEVERE**
   Clinic Use_____

3. **Do you raise your eyebrows to help you see?** **NONE MILD MODERATE SEVERE**
   Clinic Use_____

4. **Do you find it difficult to drive due to visual obstruction?** **NONE MILD MODERATE SEVERE**
   Clinic Use_____

5. **Do your lids feel "heavy" & push down your eyelashes?** **NONE MILD MODERATE SEVERE**
   Clinic Use_____

6. **Do you find yourself tilting your head back in order to see?** **NONE MILD MODERATE SEVERE**
   Clinic Use_____

7. **Do you have difficulties reading, watching TV or computer?** **NONE MILD MODERATE SEVERE**
   Clinic Use_____

8. **Do you get frequent headaches due to eye strain?** **NONE MILD MODERATE SEVERE**
   Clinic Use_____

9. **Do your eyes water and tear?** **NONE MILD MODERATE SEVERE**
   Clinic Use_____

10. **Do you bump into things because of your inability to see?** **NONE MILD MODERATE SEVERE**
    Clinic Use_____

11. **Have you ever used over the counter or prescription medications or drops to help you with your eyelid concerns?** **Yes No**

_____

Patient Signature Print Name DOB Date

Reviewed by: _____MD _____Date

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EYELID AND SKIN LUMP/GROWTH

The doctor would like to know more information about your eyelid or skin lump or growth

LOCATION OF LUMP OR GROWTH _____

Date you first noticed the lump or growth_____

Has the lump or growth changed in size YES NO

If yes over what period of time _____ DAYS WEEKS MONTHS YEARS

Has the lump or growth changed in color or appearance YES NO

If yes over what period of time: _____ DAYS WEEKS MONTHS YEARS

Does the lump or growth ever bleed YES NO

Do you personally have a history of skin cancer YES NO

If yes what type of cancer Basal Cell Squamous Cell Melanoma Other

Do you have a family history of skin cancer YES NO

Does clothing or jewelery irritate this lump or growth YES NO

Does the lump or growth itch YES NO

Does the lump or growth affect your daily life YES NO

If yes how _____

What is your biggest concern regarding this lump or growth

_____

_____

Patient's Name (Please Print)_____

Patient's Signature _____ Date_____

Reviewed by Physician _____ Date_____

Physician's Findings _____

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CONSENT FOR MEDICAL PHOTOGRAPHS

I, _____, give my consent to Aesthetic Eye Associates, PS, or any person designated by Dr. Steven LauKaitis or Dr. Bryan Sires to photograph me during the course of my treatment(s) in order to demonstrate any condition or disorder, subsequent therapy, including surgical procedures when I may be sedated or anesthetized, and the results of such therapy. **I understand that such photographs will be treated as confidential except as authorized by me in writing.** I agree that such photographs become the sole property of Allure Laser Center and Medispa and that they may dispose of them at any time.

PATIENT SIGNATURE: _____ DATE: _____

WITNESS TO SIGNATURE ONLY: _____ DATE: _____

AESTHETIC EYE ASSOCIATES, PS - MEDICATION RECONCILIATION FORM

PATIENT NAME: DOB:

LIST ALL ALLERGIES / SENSITIVITIES / UNTOWARD REACTIONS:

LIST ALL PRESCRIPTION & OTC MEDICATIONS WITH DOSAGE & FREQUENCY:			
NAME	DOSAGE	FREQUENCY	**(ASC USE ONLY)**

ALLERGIES / SENSITIVITIES / UNTOWARD REACTIONS & MEDICATIONS REVIEWED BY:		
DATE / INITIALS / CREDENTIALS	DATE / INITIALS / CREDENTIALS	DATE / INITIALS / CREDENTIALS

[PATIENT LABEL]

AESTHETIC EYE ASSOCIATES, PS - HEALTH HISTORY QUESTIONNAIRE

Patient Name: DOB:

Please answer all questions	Y	N	Please answer all questions	Y	N	Please answer all questions	Y	N
CARDIOVASCULAR			**RESPIRATORY**			**ENDOCRINE**		
High blood pressure			Shortness of breath w/ exertion			Diabetes controlled w/insulin		
Coronary artery disease			Asthma			Diabetes controlled w/oral meds		
History of heart attack			Emphysema/COPD			Diabetes controlled w/diet		
Congestive heart failure			Chronic bronchitis			Lupus		
Heart valve disease/murmur			Recent/chronic cough			Thyroid disease		
Blocked circulation to carotid arteries			Recent respiratory infection/pneumonia			Scleroderma		
Have a pacemaker			Obstructive sleep apnea			Rheumatoid Arthritis		
Blocked circulation to limbs			Use a CPAP machine			Other:		
Irregular heart rhythm			Regular oxygen use			**GI**		
History of stent			Other:			GERD/acid reflux		
History of CABG			**KIDNEY/LIVER**			Hiatal Hernia		
Angina/chest pain			Renal Insufficiency/Kidney Failure			Barrett's Esophagus		
Abdominal Aortic Aneurysm			Frequent UTI's			Crohn's		
Other:			Missing kidney/dialysis			Diverticulitis/Ulcerative colitis		
CLOTTING			Liver disease			Other:		
Bruise easily			Other:			**MUSCULOSKELETAL**		
Frequent nose bleeds			**PSYCHOLOGICAL**			Arthritis		
Other:			Dementia/Alzheimer's			Chronic pain/Fibromyalgia		
NEUROLOGICAL			Anxiety or depression			Restless leg syndrome		
History of stroke/TIA			Post-traumatic stress disorder			Scoliosis		
Seizure disorder			Bipolar disorder			Joint replacement		
Multiple sclerosis			Other:			Other:		
Parkinson's			**SKIN**			**DISEASES/CONDITIONS**		
Other:			Slow or poor wound healing			Hepatitis, A, B, C date:		
WOMEN ONLY			Cold sores, herpes, shingles			MRSA, VRE, VISA, VRSA		
Pregnant/Breastfeeding			Psoriasis, eczema			HIV/AIDS		
Hysterectomy			Skin cancer			Tuberculosis		
Date of last menstruation:			Type:			Other:		
Other:			Other:			**SOCIAL HABITS**		
ANESTHESIA			**OTHER**			Smoking		
Problems w/ general anesthesia			Mobility Restrictions			Amount/day for how many years:		
Reaction:			Type:			Alcohol use:		
Problems w/ conscious sedation			Hospitalized within last year			Drinks/day, week, month:		
Reaction:			When/Why:			Medical Marijuana use		
Problems w/ local anesthesia			Recent changes in health			Recreational drug use		
Reaction:			Recent travel outside the US			Drug/Frequency:		

ADDITIONAL HEALTH INFORMATION/COMMENTS:

DATE / INITIALS / CREDENTIALS	DATE / INITIALS / CREDENTIALS	DATE / INITIALS / CREDENTIALS

Patient Signature:_____ Date/Time:_____

Witness to Signature only:

[PATIENT LABEL]