Client Information Form

Today's Date: ______________________________

Known Food or Medication Allergies: ____

Name: (Last)_____________________________(First)_____________________________(MI)_____

Name you prefer to be called: ____

How did you hear about us?:____

Patient Address: _______________________________________City: __________________________

State: ______________________Zip: _____________________

Email Address:_________________________________Fax number:____________________________

Primary Contact Phone: __________________Secondary Contact Phone: _____________________

Please circle the phone number on which we can leave confidential voicemail messages.

Birth Date: ____________________________________Age: ______________Sex: M F

Marital Status: ____single ____married ____separated ____widowed ____divorced

Spouse's name (if applicable) ____

Preferred pharmacy:_______________________________Number:______________________________

Employment Information:

Employer: _________________________________ Occupation: _______________________________

Work phone No: ____

In Case of Emergency:

Name: __________________________________Relationship: ______________ Phone: ____________

Primary Care Physician: ____ Phone: ______________

Clinic Policies

Primary Care Physician Policy:

Thank you for selecting Dr. Evelyn Ding for your wellness and aesthetic needs. She is honored to be of service to you. As a Consultant entity, we ask that you continue your relationship with your primary care doctor so that you may be seen in the case of acute illness, colds, or other ambient maladies. Dr. Ding is not available for consultations outside clinic hours and does not take call at a local hospital. It is important to her that you have a physician who can take emergency call and/or understand that you need to report to the nearest Emergency Room if an acute medical condition arises.

Medical Monitoring Policy:

In order to ensure our patients are being medicated properly and maintaining good health, Dr. Ding requires frequent patient monitoring including but not limited to: blood testing, urine testing, EKG, office visits, etc. These tests may be required before certain medications are prescribed or refilled. Please understand that it is for your safety and well-being that Dr. Ding requires these tests.

Medication Refill Policy:

Dr. Ding may approve or deny your medication based on your needs, current laboratory results, and her professional judgement. We ask that you call your pharmacy when you are nearing the end of your medication supply. Our office generally is able to process refill requests in 48 hours.

Laboratory Testing Before Office Visits:

Dr. Ding prefers patients have labs completed before their scheduled appointment so that your office visit can be as efficient and productive as possible. We encourage you to call the office 512-407-9790 or email 1-2 weeks before your appointment to obtain a labslip for blood testing and/or any other required tests.

Aesthetic Procedure Booking Policy:

Certain Scheduled Aesthetic procedures require a non-refundable deposit at the time of scheduling. This $200 fee will be credited to your balance on the day of your procedure. Cancellations without 24 hours notice will result in a $50 charge. The remainder of the deposit may be used for other services at the clinic.

Cancellation Policy:

No-shows and appointments cancelled without 24 hours notice will be automatically charged a $50 fee. This fee will be collected either at your next visit or at the end of the month, which ever comes first. If you have a change in your schedule and are not able to make your appointment, please contact the office at your earliest convenience. We understand that conflicts and emergencies do arise and are always happy to reschedule appointments at a time that is more convenient for you.

I am aware that I will be charged $50 for any missed or cancelled appointments. **Initial Here _______**

Insurance Policy:

Medical insurance is not accepted for in-office visits and procedures. However, we are able to have local labs and radiology facilities bill your insurance for any lab work or further testing that is necessary. If requested, we can provide you paperwork to submit to your insurance company for reimbursement purposes.

If payment is a concern, we do accept CareCredit. CareCredit is an alternative way to finance your medical bills by using monthly payments. If you are interested, please ask any of our staff to explain the program.

I am aware of the insurance policy. **Initial Here _______**

Financial Policy:

Please be advised that payment for all services will be due at the time services are rendered. For your convenience, we accept Visa, MasterCard, cash, checks, and Care Credit. We are unable to accept personal checks.

I agree that I will be responsible for all collection costs/attorney's fees/court costs, should this account be referred to an agency or an attorney for collection. **Initial Here _______**

By signing this document, I acknowledge that I have read and understand all of the policies described above and have agreed to the above statements.

Client Signature:_______________________________________Date:_____________________________

Printed Name: ____

Medical History

Name:________________________________DOB:_____________________Date:__________

Are you in good health at the present time to the best of your knowledge? ____Yes ____No

Are you under a doctor's care at the present time? ____Yes ____No

If yes, please specify the conditions being treated ____

____

____

MEDICINES

Are you allergic to any medications? ____Yes ____No

If yes, please specify ____

Please list all the medications you are presently taking (prescription and over-the-counter). Include dose and frequency.

____

____

____

____

____

Have you ever been hospitalized? ____Yes ____No

If yes, please specify____

____

Have you had or do you have any of the following conditions? Please check all that apply.

____high blood pressure ____heart disease ____chest pain ____heart valve damage

____heart murmur ____irregular heart beat ____shortness of breath ____feet/ankle swelling

____dizziness ____stroke ____varicose veins ____leg cramps

____blood clots ____bleeding disorder ____circulatory deficiency in the legs or feet

____severe headaches ____seizures ____fainting spells ____numbness/ tingling

____diabetes ____low blood sugar ____indigestion ____nausea

____vomiting ____abdominal pain ____diarrhea ____constipation

____stomach ulcers ____liver disease ____gallbladder disease ____intestinal disease

____high cholesterol ____anemia ____gout ____arthritis

____osteoporosis ____kidney disease ____kidney stones ____urinary tract infection

____asthma ____chronic cough ____allergies ____depression

____bipolar disorder ____anorexia ____bulimia ____alcohol/ drug abuse

____low thyroid ____overactive thyroid ____glaucoma ____other

Other Conditions: (please list) ____

Personal Success Wellness

SURGICAL HISTORY (please list)

Date Surgeon Procedure

_______________ _______________ _______________________________________

_______________ _______________ _______________________________________

_______________ _______________ _______________________________________

_______________ _______________ _______________________________________

FAMILY HISTORY

Please check off any medical diseases that run in the family. List which family member(s) has the disorder.

____high blood pressure____

____diabetes____

____heart disease____

____stroke____

____thyroid disorders____

____cancer____

____depression/ other psychiatric dx's ____________________________________

____other disorders (like glaucoma, asthma, seizures, kidney disease) Please specify__________

____

SOCAL HISTORY

Do you smoke? ____yes ____no Have you ever smoked? ________________________

If yes, how many years?________ How many packs per day?____________________

Do you drink alcohol regularly? ____yes ____no

If yes, how many drinks and how often?______________________________________

GYNECOLOGIC HISTORY (women only)

Pregnancies: number______ delivered______ abortions or miscarriages______

Are your periods regular? ____yes ____no

Length of periods______days Length of cycle________days

Date that last menses started:___________________________

Are you taking birth control pills? ____yes ____no Hormones? ____yes ____no

Other contraceptive methods____

Age of menopause (if applicable)____

Date of last check up____

With Dr.____

Signature of patient:__________________________________ Date:_____________________________________

Consent to Use and Disclosure of Protected Health Information
HIPPA FORM

Use and Disclosure of your Protected Health Information
Your Protected Health Information will be used by Dr. Evelyn Ding and staff ,
or disclosed to others for the purpose of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices
You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office.
You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

Requesting a Restriction on the Use or Disclosure of Your Information
You may request a restriction on the use or disclosure of your Protected Health Information.

This office may or may not agree to restrict the use or disclosure of your Protected Health Information.

If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent
You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change privacy practice
This office reserves the right to modify the privacy practices outlined in the Notice.

Signature
I have reviewed this consent form and give my permission to this office to use and disclose my health information in accordance with it.

____
Name of Patient (Print)

____
Signature of Patient Date

____
Signature of Patient Representative

____
Relationship of Patient Representative to Patient

____
Office Representative Date