

# Glen Lau, M.D.

PLASTIC AND RECONSTRUCTIVE SURGERY  
Surgery of the Hand and Wrist

80 Grand Avenue, Suite 810  
Oakland, CA 94612  
(510) 451-6950 / (510) 451-0785 fax

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San Francisco, CA 94108  
(415) 393-9600

[www.bayplasticsurgery.com](http://www.bayplasticsurgery.com)

## PATIENT INFORMATION

REFERRED BY \_\_\_\_\_ DATE \_\_\_\_\_

LAST \_\_\_\_\_ FIRST \_\_\_\_\_ MIDDLE \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_

HOME TELEPHONE \_\_\_\_\_ WORK \_\_\_\_\_ CELL \_\_\_\_\_

E-MAIL ADDRESS \_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

DRIVERS LICENSE# \_\_\_\_\_

MARITAL STATUS  S  M  D  W

NAME OF SPOUSE OR PARTNER \_\_\_\_\_

IN CASE OF EMERGENCY NOTIFY \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

TELEPHONE \_\_\_\_\_

EMPLOYER NAME \_\_\_\_\_ OCCUPATION \_\_\_\_\_

WORK ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_

## INSURANCE INFORMATION

PRIMARY INSURANCE \_\_\_\_\_

ID# \_\_\_\_\_ GROUP # \_\_\_\_\_

INSURANCE ADDRESS \_\_\_\_\_

SECONDARY INSURANCE \_\_\_\_\_

ID# \_\_\_\_\_ GROUP # \_\_\_\_\_

INSURANCE ADDRESS \_\_\_\_\_

## MUST BE SIGNED

ASSIGNMENT OF BENEFITS: I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO MYSELF OR THE NAMED PROVIDER FOR PROFESSIONAL SERVICES RENDERED.

SIGN \_\_\_\_\_ DATE \_\_\_\_\_

RELEASE OF INFORMATION: I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM.

SIGN \_\_\_\_\_ DATE \_\_\_\_\_

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## MEDICAL HISTORY

NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

PRESENT MEDICATIONS \_\_\_\_\_

ALLERGIES (medication name) \_\_\_\_\_

PREVIOUS OPERATIONS (when & where) \_\_\_\_\_

PREVIOUS HOSPITALIZATIONS (when & where) \_\_\_\_\_

### PERSONAL HABITS

Have you ever smoked?  YES  NO packs/day? \_\_\_\_\_ How many years? \_\_\_\_\_ If you quit, when? \_\_\_\_\_

Do you drink Alcohol?  YES  NO If yes,  Daily  Occasionally

Do you use recreational drugs?  YES  NO Have you ever use intravenous drugs?  YES  NO

### MEDICAL CONDITIONS

PLEASE INDICATE YES OR NO TO THE FOLLOWING QUESTIONS

Have you ever had any of the following?

	YES	NO		YES	NO		YES	NO
Heart Problems			Thyroid Problems			Stroke		
High Blood Pressure			Kidney Problems			Venereal Disease		
Irregular Pulse			Hepatitis/Jaundice			High Risk for AIDS		
Chest Pain/Angina			Hiata Hernia/Heartburn			Steroid Treatments		
Respiratory Problems			Ulcers			Alcohol/Drug Addiction		
Asthma			Bleeding Problems			Special Diet		
Fainting			Transfusions			Tuberculosis		
Seizures/Epilepsy			Anemia			Difficulty Urinating		
Numbness/Weakness			Arthritis			History of Child Abuse		
Diabetes			Back Pain			HIV Infection		
Possible Pregnancy?			Neck Stiffness			Alternate Health Treatment		

### FAMILY HISTORY

PLEASE CHECK ALL THAT APPLY

RELATIVE	LIVING	DEAD	CAUSE OF DEATH
Father			
Mother			
Spouse			
Children			

Has any blood relative?

	YES	NO	IF YES, INDICATE WHICH RELATIVE
Had early heart disease?			
Been an alcoholic/drug addict?			
Had Gout?			
Had unusual bleeding tendencies?			
Had death during anesthesia?			

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**CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

**Patient's Name** \_\_\_\_\_

Pursuant to the requirements found in the Health Insurance Portability and Accountability Act of 1996(HIPPA) the following is offered for your information and consent. Please be aware that it is office's policy to require your reading and signing this consent from prior to the provision of treatment or any other medical services.

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examinations and test results, diagnosis, treatment and any plans for future car treatment.

**I understand that this information serves as:**

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis 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 care quality and reviewing the competence of healthcare professionals.

**I understand that I have the right:**

- To object to the use of my health information for directory purposes.
- To request restrictions as to 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.
- To revoke this consent in writing, except to the extent that the organization has already taken in reliance thereon.

I request the following restrictions to the use or disclosure of my health information.

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

\_\_\_\_\_  
Signature of patient or Legal Representative

\_\_\_\_\_  
Date

**OFFICE USE ONLY**

Accepted

Denied

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**FINANCIAL RESPONSIBILITY**

***Patients must read the following carefully and sign below:***

Payment of all charges relating to the evaluation and treatment of medical condition is solely the responsibility of the patient. Insurance payments may offset or entirely cover these costs. However, the patient or the financially responsible agent listed below alone accepts all financial responsibility for medical evaluations and treatments rendered.

Currently, Dr. Lau is NOT a preferred provider on any insurance plan. Recognizing this, we provide the same courtesy to our patients as if we were a contracting provider by extending patients the contracting rates offered by their insurance policy.

For our surgery patients: You will receive two separate bills for your surgery. One bill reflects the professional component (the doctor's charges). The second bill reflects the facility fees (the operating room, nurses, supplies, etc.) and may come from the surgery center or hospital depending on where your surgery takes place. The doctor's charges and the facility fees are currently billed by Medical Forefronts Financial Services, LLC, our outside billing company. If you have any questions regarding your statements, feel free to call our office and we will be happy to direct you to the appropriate contact.

If your insurance policy has a CAP (maximum amount they will allow for a procedure) and you decide to go ahead with a procedure, you will be responsible for the fee above and beyond the CAP. **It is the patient's responsibility to know their own insurance plan and understand their benefits.**

The undersigned as patient or as agent accepts complete financial responsibility for all charges in full whether or not paid by insurance. Insurance includes Medicare, Private insurance, Disability Payments, Workers Compensation, Legal Settlements and other Health Plans.

Name of Patient (please print) \_\_\_\_\_  
Signature of Patient \_\_\_\_\_ Date \_\_\_\_\_

Name of Financially Responsible Party (please print) \_\_\_\_\_  
Signature of Responsible Party \_\_\_\_\_ Date \_\_\_\_\_

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*'Dr. Glen Lau and Dr. Douglas Chin are not partners or otherwise affiliated in the same medical practice. They are independent practitioners who simply share office space, equipment, and staff in their separate practices. They are not responsible for each other's practices or patients.'*

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date