PEGGY M. LIAO, M.D.
Pediatric Ophthalmology and Strabismus
1319 Punahou Street, Suite 620
Honolulu, HI 96826

PATIENT INFORMATION SHEET
(please print)

PATIENT

Last _____
First _____
Middle Initial _____
Male _____ Female _____
Birthdate _____
Social Security # _____

Mailing Address _____
City _____State _____ Zip _____

Primary Phone (_____) _____
Secondary Phone(_____) _____

Referring Doctor_____

MEDICAL INSURANCE

Primary Insurance _____
Name of Subscriber _____
Birthdate of Subscriber _____
Membership # _____

Secondary Insurance _____
Name of Subscriber _____
Birthdate of Subscriber _____
Membership # _____

RESPONSIBLE PARTY

Relationship _____

Last Name _____
First Name _____
Middle Initial _____
Birthdate _____

Mailing Address _____
City _____ State _____ Zip _____

Primary Phone (_____) _____
Secondary Phone(_____) _____
Work Phone (_____) _____

Occupation _____
Employer _____
Social Security # _____

Emergency Contact

Name _____
Relationship to Patient _____
Phone Number _____

____ Initial

INSURANCE BENEFIT ASSIGNMENT

I request payment of authorized benefits to be paid on my behalf to Peggy M. Liao, M.D. for any services furnished by Peggy M. Liao. I authorize Dr. Peggy M. Liao to release medical information about me/child to my insurance carrier(s).

_____ Initial

NOTICE OF PRIVACY PRACTICES

I have read a copy of Peggy M. Liao, M.D. privacy practices. (Copy to view/read available upon request.)

_____ Initial

MISSED APPOINTMENT

Twenty-four (24) hour notice is required prior to the appointment to let us know that you will not be keeping your appointment. You can call our office at 808-949-4558 to cancel or re-schedule your appointment. **After 3 missed appointments, in total**, you may receive a written notification in the mail, discharging you from our practice.

_____ Initial

ELIGIBILITY WAIVER

I understand that, if it is required, a referral/authorization must be sent from my/my children's primary care doctor to Dr. Peggy Liao **before** I can be seen. If Dr. Liao does not receive this referral/authorization from the primary care doctor, I am liable for all charges.

I understand that eye exams for certain diagnoses may not be covered by some insurance plans, and that any charges not covered by insurance(s) are my responsibility, **including any deductibles, coinsurance, or non-covered service.** I also understand that if the patient is not eligible under the terms of the insurance(s) specified above or if the above is a misrepresentation of my coverage, I am liable for all charges for services rendered, and I agree to pay in full for all services received within thirty (30) days of receiving a bill from the above-named doctor.

***Co-payments are due at time of service.**

_____
Patient, Parent or Legal Guardian Signature

Relationship _____

Date_____