M Polly McKinstry MD
23961 Calle dela Magdalena, #402
Laguna Hills CA 92653

PATIENT INFORMATION

MARITAL STATUS: M S W D

NAME: _____ SEX: _____ DATE OF BIRTH: _____ AGE: _____

ADDRESS: _____ DL# OR ID#: _____
CITY STATE ZIP

HOME PHONE ( ) _____ CELL PHONE ( ) _____

SOCIAL SECURITY #: _____ WORK RELATED INJURY? Y / N DATE OF INJURY: _____

REFERRED BY: _____ PHONE ( ) _____

OCCUPATION: _____ EMPLOYER: _____
COMPANY NAME

ADDRESS: _____ WORK PHONE ( ) _____
CITY STATE ZIP

EMAIL ADDRESS: _____ NAME OF SPOUSE: _____

SPOUSE DATE OF BIRTH: _____ AGE: _____ EMPLOYER: _____

EMPLOYER ADDRESS: _____

FRIEND/RELATIVE NOT LIVING WITH YOU: _____ RELATIONSHIP TO PATIENT: _____

ADDRESS: _____
CITY STATE ZIP PHONE

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ PHONE: _____

ADDRESS: _____ SUBSCRIBER _____
CITY STATE ZIP PHONE

RELATIONSHIP TO PATIENT: _____ SUBSCRIBER # _____ GROUP # _____

SUBSCRIBER'S DATE OF BIRTH: _____

SECONDARY INSURANCE: _____ PHONE: _____

ADDRESS: _____ SUBSCRIBER: _____
CITY STATE ZIP PHONE

RELATIONSHIP TO PATIENT: _____ SUBSCRIBER # _____ GROUP # _____

SUBSCRIBER'S DATE OF BIRTH: _____

I HEREBY AUTHORIZE AND DIRECT MY INSURANCE CARRIER TO PAY DIRECTLY TO THE PHYSICIAN, NAMED ABOVE, ANY BENEFITS DUE ME UNDER MY INSURANCE PLAN. I AGREE TO PAY THE BALANCE OF EXPENSES NOT PAID UNDER THIS PLAN. I AUTOHORIZE THE PHYSICIAN TO RELEASE TO MY INSURANCE CARRIER ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM.

POINT OF SERVICE PATIENTS: I UNDERSTAND THAT I MAY BE RESPONSIBLE FOR AN ADDITIONAL CO-PAY IF I HAVE GONE "OUT-OF-NETWORK" (ACCORDING TO INDIVIDUAL PLAN GUIDELINES).

AUTHORIZED SIGNATURE: _____ DATE: _____
SIGNATURE OF PATIENT OR PARENT IF PATIENT IS A MINOR

PATIENT HEALTH HISTORY

NAME OF PRIMARY CARE PHYSICIAN OR INTERNIST: _____

NAME OF EYE DOCTOR: _____ DATE OF LAST EYE EXAM: _____

NAME OF DERMATOLOGIST: _____

REASON FOR YOUR VISIT TODAY: _____

PLEASE CIRCLE ANY OF THE FOLLOWING CONDITIONS/SERVICES IN WHICH YOU MAY BE INTERESTED:

TEARING THYROID EYE DISEASE NODULE/BUMP REMOVAL

EYELID RECONSTRUCTIVE SURGERY COSMETIC SURGERY/LASER SURGERY

DO YOU HAVE A HISTORY OF THE FOLLOWING:

_____ALCOHOL CONSUMPTION	_____HEART ATTACK	_____TOBACCO USE*
_____BLOOD TRANSFUSION	_____HEPATITIS	_____TEARING PROBLEM
_____CANCER	_____HIGH BLOOD PRESSURE	_____THYROID DISORDER
_____CATARACTS	_____KIDNEY DISEASE	_____TUBERCULOSIS
_____DIABETES	_____PROSTHESIS – HIP/KNEE	_____OTHER
_____GLAUCOMA	_____SLEEP APNEA	

*SMOKING HISTORY

HAVE YOU EVER SMOKED: YES NO

IF SO, HOW MANY PACK PER DAY: _____ HOW MANY YEARS: _____

LIST YOUR CURRENT MEDICATIONS, INCLUDING EYE DROPS AND OVER THE COUNTER MEDICATIONS:

_____

_____

_____

ARE YOU ALLERGIC/SENSITIVE TO ANY MEDICATIONS?

_____

_____

_____

PLEASE LIST EYE SURGERIES AND/OR EYE LASER PROCEDURES YOU HAVE UNDERGONE:

_____

_____

_____

PLEASE LIST ALL OTHER SURGERIES:

_____

_____

_____

M. Polly McKinstry, M.D.

Agreement of Financial Responsibility

A COSMETIC CONSULTATION is $200 and will be applied to your procedure if/when it is performed. All cosmetic fees are collected at the end of your visit. Medical consultations are billed to your insurance. We do not offer any free services at our office.

Our office is NOT an HMO or CalOptima provider. If you do not have a PPO option on your plan, then you will be responsible for all charges at the time services are rendered. Patients with a POS plan, please be aware that benefits will be processed as out of network.

If we do not contract with your insurance company, you will be expected to pay for all services rendered at the end of your visit. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company. If you are in doubt as to whether a procedure or test is covered, please contact your plan's member services department.

It is you your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy, and any pre-authorization requirements of your insurance process.

If we are contract with your insurance company, we will bill your insurance company first, less any copayment(s) or deductible(s), and then bill you for any amount determined to be your responsibility.

Our office will bill your medical insurance as a courtesy to you. However, it is the policy of this office not to enter any dispute with an insurance carrier. A dispute over payment of claims is the responsibility of the patient. If your insurance carrier will not make a payment for services rendered, it is your responsibility to see payment is made.

Our office accepts payments in the form of cash, personal checks, and all major credit cards. A $25 fee will be charged for all returned checks. Please understand that payment of your bill is part of your treatment.

I have read the financial polices contained above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

_____ _____

Signature of Patient/Responsible Party Date

_____

Name of Patient/Responsible Party (please print)

M Polly McKinstry, MD

Oculofacial Plastic, Cosmetic & Reconstructive Surgery

Informed Consent:

COVID-19

I understand that I am consenting to an elective treatment/procedure/surgery that is not urgent or emergent.

I also understand that the novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. I further understand that COVID-19 is extremely contagious and is believed to spread by person-to-person contact, and as a result, federal and state health agencies recommend social distancing. I understand that my doctor listed below has put in place reasonable safety measures to help reduce the spread of COVID-19.

I understand that even if I have received a negative COVID-19 test result, the test may have failed to detect the virus, or I may have become infected after I took the test. I understand that even if I do not have any symptoms, I may have a COVID-19 infection, and that having the elective treatment/procedure/surgery can lead to a higher chance of complication and death.

I understand that exposure to COVID-19 before, during, and after my treatment/procedure/surgery may result in the following: a positive COVID-19 diagnosis, extended isolation, additional tests, and hospitalization, up to and including: the need for treatment in intensive care (ICU), short-term or long-term intubation, other complications, and death. After my elective surgery I may need additional care that may require that I go to an emergency department or hospital.

I understand that COVID-19 may cause additional risks, some of which may not be known at this time.

I understand that this elective procedure may put me at increased risk for becoming infected with COVID-19. By signing this consent form I accept that risk and give my permission to proceed with the treatment/procedure/surgery listed below.

I have been given the choice to have my treatment/procedure/surgery at a later date. I understand the potential risks of delaying and want to proceed.

I have read this consent or someone has read it to me.

Name of patient:

Patient date of birth:

Name of provider:

Treatment/procedure/surgery:

Signatures:

Patient:

Date:

Provider:

Date:

M. Polly McKinstry, M.D.

Cancellation Policy/No Show Policy
For Doctor Appointments and Surgery

We understand that there are times when we must miss appointments due to emergencies or obligtions for work or family. However, when you do not call to cancel an appointment you may be preventing another patient from getting earlier treatment.
If an office appointment is not cancelled at least 24 hours in advance, you will be charged a twenty five dollar($25) fee: this will not be covered by your insurnace company. If an office minor surgery is not cancelled at least 24 hours in advance, you will be charged a fifty dollar ($50) fee.

Scheduled Appointments

We understand that delays can happen, however we must try to keep the other patients and doctor on time.
If a patient is 15 minutes past their scheduled time we will have to reschedule the appointment.

Cancellation/No Show Policy for Our Patient Surgery

Due to the large block of time needed for surgery, last minute cancellations can cause problems and added expenses for the office.
If surgery is not cncelled at least 10 days in advance you will be charged a seventy five dollar ($75) fee; this will not be covered by your insurnace company.

Account Balances

We will require that patients with self pay balances to pay their account balances to zero prior to receiving further services by our practice.
Patients who have questions about their bills or who would like to discuess a payment plan option may call and ask to speak to a billing office representative with whome they can review their account and concerns.
Patients with balances over $100 must make arrangments prior to future appointments being made.

_____	_____	_____
Print Name Patient	Signature Patient/Guardian	Date

M. Polly McKinstry, MD

OCULOFACIAL PLASTIC & RECONSTRUCTIVE SURGERY
Certified, American Board of Ophthalmology

AGREEMENT AS TO RESOLUTION OF CONCERNS

"I", "Patient/Guardian" shall be understood to mean _____
PATIENT NAME

I understand that I am entering into a contractual relationship with Dr. M. Polly McKinstry for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by Dr. M. Polly McKinstry, I, the patient/guardian and/or my representative, agree not to advance, directly or indirectly, any false, meritless, and/or frivolous claim(s) of medical malpractice against Dr. M. Polly McKinstry.

Furthermore, should a meritorious medical malpractice case or cause of action be initiated or pursued, I (the patient) and/or representative agree to use American Board of Medical Specialties (ABMS) board certified expert medical witness (es) in the same sub-specialty as Dr. M. Polly McKinstry, i.e. also certified as a fellow of the American Society of Ophthalmic Plastic and Reconstructive Surgeons (ASOPRS). Furthermore, I agree that these expert witnesses will be members in good standing and will adhere to the guidelines and/or code of conduct defined for expert witnesses by the American Medical Association.

I agree to require any attorney I hire, and any physician hired by me or on my behalf as an expert witness to agree to these provisions.

Patient and physician agree that this Agreement is binding upon them individually and their respective successors, assigns, representatives, personal representatives, spouses, and other dependents.

In further consideration for this, Dr. M. Polly McKinstry agrees to the same stipulations.

_____ _____
M. POLLY MCKINSTRY, M.D. PATIENT/GUARDIAN

_____ _____
EFFECTIVE FROM DATE OF TREATMENT DATE OF SIGNATURE

If, after reading this, you have any further questions, please do not hesitate to call the office: 949-595-0095