MICHIGAN
RETINA
CENTER

Dear Patient,

We would like to welcome you to our practice! In order to expedite your initial visit with us, we are enclosing a new patient packet. Please complete it and bring it along with the items listed below. **Please arrive at your appointment time** and note that the initial appointment may last up to 2 hours.

We look forward to meeting you. Call us at **(313) 441-2227** if you have any questions.

Please bring:

1. Identification Card (ID)
2. Insurance Card
3. Medication List
4. Insurance Referral (if necessary)
5. Sunglasses
6. Driver (your eyes will be dilated during your visit)

Appointment Information

Day: ❑ Monday ❑ Tuesday ❑ Wednesday ❑ Thursday ❑ Friday

Date: / /

Time: : ❑ AM ❑ PM

Location:

❑ **Dearborn**
25230 Michigan Ave
Dearborn, MI 48124
(*Location on north side of Michigan Ave, between Telegraph and Gulley*)

❑ **Ann Arbor**
Reichert Health Building
5333 McAuley Dr, Ste #1018
Ypsilanti, MI 48197
(*On campus of St. Joseph Mercy Hospital, Free parking in Lot J*)

❑ **Novi**
24520 Meadowbrook, Ste #100
Novi, MI 48375
(Located on east side of Meadowbrook Rd, between 10 Mile Rd and Grand River)

MICHIGAN RETINA CENTER

Registration Form

Date: _____

Patient Information:

Patient Name: _____ Date of Birth: _____

Address:_____

City: _____ State: _____ Zip Code: _____

Age: _____ Gender: ❑ Male ❑ Female

Home Phone: _____ Cell Phone: _____

Preferred Phone: ❑ Home ❑ Cell Email: _____

Patient's Language Preference: _____

❑ **Yes** ❑ **No** || Is the patient currently in a **Skilled Nursing** or **Rehab Facility** or in **Hospice**?

Race/Ethnicity:

- ❑ African American/Black
- ❑ Asian
- ❑ Caucasian/White
- ❑ Hispanic/Latino
- ❑ Native American
- ❑ Pacific Islander
- ❑ Other: _____

Emergency Contact:

Emergency Contact Name: _____ Relationship: _____

Emergency Phone Number: _____

Other Providers:

Referring Ophthalmologist/Optometrist: _____

Phone: _____ Fax: _____ Address: _____

Primary Care Physician: _____

Phone: _____ Fax: _____ Address: _____

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Insurance:

Primary Insurance Provider: _____ Policy #: _____

Subscriber Name: _____ Date of Birth: _____

Relationship to Patient: _____ Effective Date: _____

Secondary Insurance Provider: _____ Policy #: _____

Subscriber Name: _____ Date of Birth: _____

Relationship to Patient: _____ Effective Date: _____

Injury:

If patient is being seen due to an injury at work or an auto accident, please inform the front desk

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Preferred Pharmacy Name: _____

Location: _____ Phone: _____

Patient or Authorized Person Signature:

I certify the above information is true and accurate. I authorize the release of any medical or other information necessary to process a claim or continue medical treatment. I also authorize payment of medical benefits paid directly to Michigan Retina Center. I acknowledge I am responsible for payment of any balance my insurance company does not pay.

X _____

Patient or Authorized Person Signature

_____

Date

MICHIGAN RETINA CENTER

Today's Date: _____

Full Name: _____ Date of Birth: _____

Which symptoms are you experiencing?
Mark all that apply

- ❑ Blurry Vision
- ❑ Loss of Vision
- ❑ Distortion of Vision
- ❑ Floaters
- ❑ Flashes
- ❑ Pain
- ❑ Other: _____

Which eye?

- ❑ Right
- ❑ Left
- ❑ Both

Severity

- ❑ Mild
- ❑ Moderate
- ❑ Severe

Did the symptoms start…

- ❑ Suddenly
- ❑ Gradually

How long ago did your symptoms start? _____ (#) hours / days / weeks / months / years

Select all diagnoses and surgeries that apply to you, <u>presently</u> and <u>past</u>:

- ❑ Macular Degeneration Eye _____
- ❑ Retinal Tear Eye _____
- ❑ Retinal Detachment Eye _____
- ❑ Retinal Injections Eye _____
- ❑ Cataract Surgery Eye _____
- ❑ Retinal Surgery Eye _____
- ❑ Glaucoma Surgery Eye _____
- ❑ Lasik Surgery Eye _____

Please list any eye related medications and drops you are currently taking:

Name or Cap Color	***How many times a day?***	***Which eye?***

Medical History

❑ Y ❑ N Flu Vaccine (for current or upcoming flu season)

❑ Y ❑ N Pneumonia Vaccine

❑ Y ❑ N Diabetes. ❑ Type 1 ❑ Type 2 *Last HbA1c _____. On Insulin?* ❑ *Y* ❑ *N*

❑ Y ❑ N High Blood Pressure

❑ Y ❑ N Rheumatoid Arthritis. *Do you take Plaquenil?* ❑ *Y* ❑ *N. If yes, dosage:* _____

❑ Y ❑ N Kidney Disease. *Are you on dialysis?* ❑ *Y* ❑ *N. Which Days*: _____

Medical History Continued:

❑ Y ❑ N **Heart Problems** ❑ Heart Attack ❑ Angina ❑ Arrythmia ❑ Heart Failure

❑ Y ❑ N **Neurology** ❑ Stroke ❑ Seizures ❑ Alzheimer's ❑ Dementia
❑ Neuropathy ❑ Migraine ❑ Parkinson's

❑ Y ❑ N **Endocrine** ❑ Hyperthyroidism ❑ Hypothyroidism ❑ High Cholesterol

❑ Y ❑ N **Pulmonary** ❑ Pulmonary Embolism ❑ COPD ❑ Tuberculosis
❑ Asthma

❑ Y ❑ N **Genitourinary** ❑ Enlarged Prostate ❑ Prostate Cancer ❑ Kidney Stones

❑ Y ❑ N **Gastroenterology** ❑ GERD- Reflux ❑ IBS ❑ Crohn's Disease
❑ Diverticulitis ❑ Ulcers

❑ Y ❑ N **Hematology** ❑ Anemia ❑ Hepatitis ❑ Sickle Cell Disease
❑ HIV ❑ Lyme Disease ❑ Cancer - _____

❑ Y ❑ N **Rheumatology** ❑ Sjogren's Syndrome ❑ Lupus ❑ Autoimmune Disorder

❑ Y ❑ N **Psychiatry** ❑ Depression ❑ Anxiety

❑ Y ❑ N **Surgical History** ❑ Cardiac Bypass ❑ Heart Stent ❑ Pacemaker ❑ Lung Surgery
❑ Kidney Surgery ❑ Other:_____

❑ Y ❑ N **Other Diagnoses Not Listed Above**: _____

Check any of the following medications you currently take:
❑ Coumadin/Warfarin ❑ Eliquis ❑ Plavix ❑ Xarelto

Please list all other current medications you are taking
(Prescription, over the counter, herbal, and supplements)

Name	Dose/Frequency	Name	Dose/Frequency

Do you have any drug allergies? ❑ Y ❑ N _____

Smoking History
- ❑ None
- ❑ Current Smoker
- ❑ Former Smoker

Alcohol Use
- ❑ Never
- ❑ Occasionally, Socially
- ❑ Multiple Drinks Per Day

Recreational Drug Use
- ❑ No
- ❑ Marijuana
- ❑ Other: _____

Family History: (list family members)
- ❑ None
- ❑ Blindness –
- ❑ Retinal Detachment –
- ❑ Macular Degeneration –
- ❑ Cataract –
- ❑ Stroke –
- ❑ Heart Attack –
- ❑ Cancer –
- ❑ Glaucoma –
- ❑ Diabetes –

Review of Systems: Please check if you currently have any of the following symptoms

Cardiovascular	❑ Chest Pain	❑ Shortness of Breath	❑ Swelling of Feet
Constitutional	❑ Fever	❑ Weight Loss	❑ Fatigue
Endocrine	❑ Excess Thirst	❑ Excessive Urination	❑ Heat/Cold Intolerance
Gastrointestinal	❑ Abdominal Pain	❑ Diarrhea	
Genitourinary	❑ Pain/Burning on Urination	❑ Blood in Urine	
Hematology	❑ Easy Bruising	❑ Prolonged Bleeding	❑ Past Blood Transfusion
Ear/Nose/Throat	❑ Hearing Loss	❑ Sore Throat	❑ Runny Nose
Integumentary	❑ Rash	❑ Change in Mole	
Musculoskeletal	❑ Muscle Aches	❑ Joint Pain	❑ Difficulty Laying Flat
Neurologic	❑ Dizziness	❑ Headaches	❑ Scalp Tenderness
Respiratory	❑ Wheezing	❑ Cough	❑ Coughing Blood

_____ _____
Patient Signature Date

_____ _____
History Review: Physician Signature Date

For Purposes of

Treatment, Payment and Healthcare Operations

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. Each patient must read our Notice of Privacy Practices and return their signed acknowledgment of their receipt. This acknowledgement must be filed in the patient's chart.

I hereby consent to Michigan Retina Center, my health care provider, using or disclosing my protected health information for the purpose of providing health care treatment to me, obtaining payment for health care services rendered to me or to carry out the Practice's health care operations.

The full Notice of Privacy Practices provides a more detailed description of the uses and disclosures allowed by this consent. I acknowledge a copy of the Notice of Privacy Practices has been made available to me. I understand the Practice reserves the right to change the privacy practices and that I can obtain a revised copy of the notice at the front desk.

I understand that I can request restrictions on the way my health care information is used and disclosed, but I also understand that the Practice is not required to agree to any of my restrictions, but if it does, the restriction is binding on the Practice.

This authorization will remain in effect until written notice of revocation is received. I understand that I can revoke this consent in writing, at any time, but that this revocation will not apply to uses of my records between the date of this consent and the date of revocation.

***I authorize Michigan Retina Center to disclose medical records to:**

Patient Advocate Name(s)/Relationship: _____

_____ _____

Patient Name Date

_____ _____

Signature of Patient, Parent, or POA Witness Signature

For Office Use Only

____ Michigan Retina Center made a "***good faith***" effort to obtain the individual's acknowledgment of the Notice of Privacy Practice.

_____ _____

Signature of Practice Representative Date

MICHIGAN RETINA CENTER FINANCIAL POLICY

Thank you for choosing Michigan Retina Center as your healthcare provider. We are committed to providing you with high quality care and a positive experience with us. Please read the following in its entirety and sign that you have read and understand this policy.

Insurance & Insurance Collection
Please understand that insurance reimbursement can be a long process and our billing staff strives to submit your claims with efficiency and accuracy, however, it is very important that you bring all of your insurance cards to each and every appointment and notify the staff if there have been any changes to your policy. Insurance claims denied because you did not provide current and correct information will be due and payable by you. We require that you update your address, telephone and employer information with us whenever there is a change. Failure to do so may result in the patient being responsible for charges incurred. We are not responsible for delinquent accounts due to lack of receipt of statements or other correspondence. Notices are assumed to be acceptable if they are returned to us as unclaimed, forwarding order expired, or otherwise undeliverable.

Medicare and Medicare Advantage Plans
As a participating provider, we will bill your Medicare carrier and secondary insurance if applicable. **If you have a Medicare Advantage plan, you must present us with the appropriate insurance card along with your traditional Medicare card.** You are responsible for any deductible and/or co-insurance that may apply.

Medicare Patients Residing in a Rehab, Skilled Nursing Facility or Hospice Care
Patients temporarily or permanently residing in a rehab, skilled nursing facility or under hospice care often have restrictions on services approved for payment in physician offices. It is critical that you let our office staff know this information and have the facility information available even if the reason for the stay is unrelated to your eye condition. Lack of prior notification could result in the patient being responsible for the charges incurred.

HMO PLANS
You are responsible for getting proper referral information and authorizations in advance of your appointment. It is the patient's responsibility to verify with your insurance company that our physician is enrolled in your insurance plan. You will be responsible for payment for services denied by your HMO for lack of referral and/or pre-authorization.

PPO PLANS
We have agreed to accept the discounted rate from your plan, however, all deductibles, coinsurance and/or copays are <u>your</u> responsibility.

Co-payments, Co-insurance and Patient Deductibles
All co-payments, deductibles, share of costs and coinsurances are your responsibility. All copays are collected at the time of service. You will receive a statement for any balances due after insurance payment has been received and payment is expected promptly. Please contact the office immediately if you need to discuss a payment plan.

No Insurance or Services not Covered by your Insurance
Patients without health insurance or patients who have coverage but the services are not covered by your insurance are expected to pay at the time-of-service. This includes all office visits, tests, injections and surgical procedures. A 15% discount will be applied to services (excluding injectable drugs) when paid at the time of service.

Unpaid Balance Fees
Michigan Retina Center will turn over all balances not paid within 90 days to: American Profit Recovery collection agency. Please note, this may have a negative impact on your credit report.

Financial Assistance for Injectable Medications
Due to the high cost of some ophthalmic injectable medications, we ask that you investigate your insurance to better understand your benefits and also investigate insurance coverage when you have the option to switch plans. We also ask that you follow through with these available Patient Assistance Programs to minimize your potential cost for these expensive medications. We will do our best to assist you with any part of this process and are committed to helping you determine your eligibility for these programs. Physician office staff can facilitate getting you the appropriate forms to complete for these assistance programs and it is your responsibility to follow up to ensure timely submission. **Ultimately, you are responsible for any costs not covered by your insurance or drug assistance programs.**

Form Completion and Record Copying
Additional fees may be charged for form completion, including disability forms, etc. Fees vary depending on the complexity of the forms. Fees for copies of medical records will be in accordance with the State of Michigan Medical Records Access Act.

No Show Fee
Failure to show up to your scheduled appointment without prior notification will result in a $10.00 No Show Fee.

WE ACCEPT MASTERCARD, VISA, AMERICAN EXPRESS, DISCOVER, DEBIT CARDS, CHECKS AND CASH.

I have read, understand, and agree to this Financial Policy. I have completed the patient information forms and the information is true and correct to the best of my knowledge. I will notify you of any changes.

_____ Date: _____
Signature of Patient or Responsible Party

_____
Printed Name of Patient