Michigan Eyecare Institute would like to welcome and thank you for choosing our doctors for your eye care needs. Our mission is to provide the most compassionate and technically advanced surgical and medical eye care where patients and employees are treated with mutual dignity and respect.

The following services are available to you, your family members and friends:

- Complete eye care performed by sub-specialized eye physicians and surgeons.
- No stitch cataract surgery.
- Glaucoma laser therapy and treatment.
- Diabetic laser treatment and eye care.
- Reconstructive and cosmetic eyelid surgery.
- Dry eye therapy, including punctum plug replacement.
- Fluorescein Angiography & Optical Coherence Tomography.
- Computerized visual field and GDX testing to determine possible field of vision loss attributable to glaucoma.
- Full service optical boutique.
- Dry eye supplies.

HOURS

Our Livonia and Southfield offices are open from 8:00 – 4:30 (5:00 in Dearborn), Monday through Friday. If you are having a problem with your eyes after normal business hours, please page our on-call doctor at (586) 717 – 3336.

REQUIRED ITEMS AT EVERY VISIT

Due to recent changes in the healthcare insurance industry, it is extremely important to bring your insurance and identification cards to every visit so that we can continue to keep accurate information on file and obtain the necessary referrals and pre-authorizations that may be required by your insurance. Our standard office policy requires that co-payments and out-of-pocket expenses be collected at the time of service. If you currently wear glasses, please bring them to each visit and alert our front-office staff if you are interested in getting a new pair.

We look forward to meeting you!

Sincerely,

The Doctors and Staff of Michigan Eyecare Institute

Michigan Eyecare Institute

PATIENT INFORMATION FORM

Date:_____

Referred By:_____(How Did You Hear About Us) _____ City:_____

Primary Care Doctor:_____ City:_____

PLEASE PRINT CLEARLY

Name:_____Date of Birth:_____Age:_____Sex:_____

Address:_____

City, State, Zip:_____

SSN:_____Email Address (Patient Portal Access)_____

Home Phone:_____Cell Phone:_____Work Phone:_____

Employer:_____Occupation:_____

Employer City, State, Zip:_____

Circle One: Married Single Divoced Widowed

Insurance

Insurance Subscriber's Name:_____

Insurance Subscriber's Date of Birth:_____Subscriber's SSN:_____

Insurance Subscriber's Employer:_____Occupation:_____

Employer City, State, Zip:_____

****PLEASE PRESENT YOUR INSURANCE CARD TO THE FRONT DESK****

Emergency Contact:_____Phone:_____

Pharmacy:_____Phone:_____

Scanned By:_____Date:_____
Chart:_____
MEI Doctor:_____
☐ SF ☐ LIV ☐ DB

***For office use only**

Michigan Eyecare Institute

OCULAR HISTORY

Are you currently having a problem with your eyes? What brought you into our office? Please explain.

Have you ever been diagnosed with an eye condition? Are you currently using any eye drops? Please explain.

Have you ever had laser treatment or surgery on your eyes? Please explain.

Do you have a family history of glaucoma, macular degeneration, or diabetic eye diseases?

Michigan Eyecare Institute

MEDICAL HISTORY

Are you currently being treated for any of the following conditions?

High Blood Pressure	▢ Yes ▢ No Year of Diagnosis _____
Diabetes	▢ Yes ▢ No Year of Diagnosis _____ ▢ Type 1 ▢ Type 2 ▢ Insulin Dependent Last A1C / Blood Sugar & Date _____
Heart Disease	▢ Yes ▢ No Year of Diagnosis _____
Thyroid Disease	▢ Yes ▢ No Year of Diagnosis _____
Cholesterol	▢ Yes ▢ No Year of Diagnosis _____
Asthma / Emphysema / COPD	▢ Yes ▢ No Year of Diagnosis _____
Other	_____ _____

Allergies:

_____
_____
_____
_____
_____
_____
_____

Current Medications List:
(If you have a list, please provide it to the front desk)

_____
_____
_____
_____
_____
_____
_____

Past Surgical History:

_____
_____
_____
_____
_____
_____
_____

MEDICARE AUTHORIZATION FORM

I request that payment of authorized Medicare benefits be made either to me or on my behalf to the Michigan Eyecare Institute, PC for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance coverage is indicated in Item 9 of the HCFA-1500 claim form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releases of the information to the insurer or agency shown.

In Medicare-assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

I ACKNOWLEDGE THAT I HAVE READ, UNDERSTAND, AND AGREE TO THE ABOVE.

Print Name:_____

Signature:_____**Date:**_____

(Parent of Guardian Signature Required if Minor)

OFFICE POLICIES

We will submit claims to your insurance company with the information **provided.** Please be sure to include all insurance information in the correct order. If you do not have your insurance card, we will be unable to submit your claim. You will be responsible for the charges when services are rendered.

If is your responsibility to obtain any insurance related referrals/authorizations prior to your visit. We will not be able to call primary care physicians on the day of your visit. **If the referral has not been obtained prior to your appointment, you will be asked to pay on the date of service or reschedule your appointment.**

I ACKNOWLEDGE THAT I HAVE READ, UNDERSTAND, AND AGREE TO THE ABOVE.

Print Name:_____

Signature:_____**Date:**_____

(Parent of Guardian Signature Required if Minor)

Michigan Eyecare Institute

AUTHORIZATION TO PAY BENEFITS TO PHYSICIANS & NOTICE OF PRIVACY PRACTICES

I request payment of authorized _____(Your Insurance Name)_____ benefits to be made either to me, or on my behalf, to the Michigan Eyecare Institute for any services furnished. I authorize any holder of medical information about me, to release to my insurance company, any information needed to determine these benefits or the benefits payable for related services. I understand that Michigan Eyecare Institute submits their insurance claims through the Misys Healthcare systems electronically and I authorize them to do so.

I hereby authorize payment directly to the Michigan Eyecare Institute and its physicians for surgical and/or medical benefits, otherwise payable to me, for their services.

I acknowledge information given to the Michigan Eyecare Institute, regarding my insurance is accurate. If it is not, and the Institute must re-bill on my behalf, I understand I will be subjected to a re-billing charge.

Financial Responsibility:

In consideration of the professional services provided to the patient, I guarantee payment of any physician charges, which are not covered by any health benefit program, including deductibles and coinsurance amounts. I understand that I will be sent a statement in the mail stating my balance.

If it is necessary to fax or transport my medical records from one office to another during my treatment, I hereby authorize Michigan Eyecare Institute to do so. I also understand that if I was referred by another physician, a letter of my progress will be sent to him/her. If a physician at the Michigan Eyecare Institute finds it necessary to refer me to another physician, I authorize the Michigan Eyecare Institute staff to provide that physician with all necessary information. I understand that my file may be used in a random chart audit by the Michigan Eyecare Institute Compliance Committee which helps to maintain their high standard of care.

I understand that it is Michigan Eyecare Institute's policy to confirm my appointments 1-3 days in advance. This may require that a message may be left on my answering machine, voicemail or with a person answering the phone. I also understand that a recall card may be sent to my home to remind me to make an appointment with my physician at the Michigan Eyecare Institute. Our practice may release medical information to an authorized friend or family member that is involved in your care, or who assists in taking care of you.

It may be necessary for our practice to release your medical information to a health agency for activities authorized by law. This may include investigations, inspections, audits,

(Page 1/2 Cont. Next Page)

(Page 2/2 Cont. Prev. Page)
surveys, licensure, and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

Our practice may disclose your medical records in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your medical records in response to a discover request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

You have the right to inspect and obtain a copy of your medical records, including your billing records. You must submit your request in writing to our office. The Medical Records Act states that if a patient or their authorized representative requests a copy of all or part of the patient's medical records, a fee may apply.

You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to our office. We may deny your request if you ask us to amend information that is in our opinion accurate and complete.

I ACKNOWLEDGE THAT I HAVE READ, UNDERSTAND, AND AGREE TO THE ABOVE.

Print Name:_____

Signature:_____**Date:**_____

(Parent of Guardian Signature Required if Minor)

FINANCIAL POLICY

Thank you for choosing our practice as your healthcare provider. We are committed to building a successful physician-patient relationship with you and your family. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. Please ask if you have any questions about our fees, our policies, or your responsibilities. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance information, etc).

Co-Pays and Deductibles
All copayments, deductibles, and past due balances are due at time of check-in unless previous arrangements have been made with a billing coordinator. We accept cash, check, or credit cards. Absolutely no post-dated checks will be accepted.

Insurance Claims
Insurance is a contract between you and your insurance company. In most cases, we are NOT a party of this contract. We will bill your primary insurance company as a courtesy to you. In order to properly bill your insurance company, we require that you disclose all insurance information including primary and secondary insurance, as well as any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company does not pay for any of your services performed at our office, you may be responsible for the complete balance of the non-payable services. If we are out of network with your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately.

Workers' Compensation and Automobile Accidents
In the case of a workers' compensation injury or automobile accident, you must obtain the claim number, phone number, contact person, and name and address of the insurance carrier prior to your visit. If this information is not provided, you will be asked to reschedule your appointment or pay for your visit at the time of service.

Missed Appointments
Appointments missed and are not previously canceled may be charged a fee of $25.00. Excessive cancellations and no-showed appointments may be subject to discharge from the practice.

Initials_____

Refractive Fee
The determination of the refractive state of your eyes is rarely covered by medical insurance and never covered by Medicare. If your insurance does not provide coverage for this service, you will be asked to pay $40.00 for this service when it is provided.

Returned Checks
The charge for a returned check is $25.00 payable by cash or money order. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash or credit card only basis following any returned check.

Minors
The parent(s) or guardian(s) is responsible for full payment and will receive the billing statement. The parent(s) or guardian(s) must stay with any minor throughout the exam.

Outstanding Balance Policy
It is our office policy that all past due accounts be sent three statements,. If payment is not made on this account, a single phone call will be made to try to make payment arrangements. If no resolution can be made, the account will be be sent to a collection agency, or attorney, and possible discharge from the practice.

In the event an account is turned over for collections, the person financially responsible for the account will be responsible for all collections costs , including attorney fees and court costs.

Regardless of any personal arrangements that a patient might have outside of our office, if you are over eighteen years of age and receiving treatment, you are ultimately responsible for payment of the service. Our office will not bill any other party.

I, _____ have read the above financial policy and understand my financial responsibility to my healthcare provider.

_____

Patient Signature Date

_____

Witness Date

NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge receipt of the Notice of Privacy Practices from Michigan Eyecare Institute. The Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to review it carefully. The Notice of Privacy Practices is subject to change. If the Notice is changed, you may obtain a revised copy by visiting our website at www.micheyecare.com or on request from our staff.

I acknowledge receipt of the Notice of Privacy Practices from Michigan Eyecare Institute.

Print Name:_____

Signature:_____**Date:**_____

(Parent of Guardian Signature Required if Minor)