Patient Name:
DOB:
Patient Number:

Understanding and Agreement of:

- I consent to the necessary treatment for the above named patient and acknowledge receipt of the Notice of Privacy Practices.
- I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable.
- I request and authorize that payment of my insurance benefits be made on my behalf to the doctor and associates providing my care and/or to the Michigan Eyecare Institute, if the organization participates with my insurance.
- I allow fax/electronic transmittal of my medical records if necessary.
- I understand that payment of charges incurred is due at the time of services unless other financial arrangements have been made prior to my treatment.
- I understand that I am responsible for my copay and/or deductible at the time of service.
- I agree to accept full financial responsibility for my office visit, testing and/or surgery if I did not obtain a referral from my primary care physician.

Signature of patient or Legal Guardian *Date*

With whom may we discuss your medical care:

Name: ______________________ Relationship: ______________________

Name: ______________________ Relationship: ______________________

Name: ______________________ Relationship: ______________________

FOR MINORS - In my absence, I permit Michigan Eyecare Institute to treat my child if accompanied by the following adult:

Name: ______________________ Relationship: ______________________

Name: ______________________ Relationship: ______________________

PATIENT MEDICAL HISTORY QUESTIONNAIRE

Name:___________________________ Acct. #:___________________________ Date:___________________________

Date of Birth:___________ Age:__________ Race:__________ Ethnicity:__________ M:_______ F:_______

PLEASE CHECK BOX IF THE ANSWER IS YES TO ITEMS BELOW:

☐ Cataracts ☐ Retinal Disorders ☐ Macular Degeneration
☐ Glaucoma ☐ Diabetic Retinopathy ☐ Corneal Problems

FAMILY HISTORY:

☐ Cancer ☐ Diabetes ☐ Hypertension ☐ Heart Disorders
☐ Glaucoma ☐ Macular Degeneration ☐ Retinal Disorders

PLEASE CHECK BOX IF YOU HAVE ANY OF THE FOLLOWING HEALTH CONDITIONS:

☐ **Cardiovascular**
- ☐Heart Attack
- ☐ Angina
- ☐ Stroke
- ☐ High Blood Pressure
- ☐ Pacemaker/Defibrillator
- Other:________________

☐ **Endocrine**
- ☐ Diabetes
- ☐ Thyroid
- Other:_____ ___________

☐ **Stomach/Intestinal**
- ☐ Ulcers
- ☐ Colitis
- Other:_____ ___________

☐ **Ocular Surface Disease**
- ☐ Itchy eyes
- ☐ Red eyes
- ☐ Watery eyes
- ☐ Swollen eyes

☐ Dry Eye

☐ **Hematologic**
- ☐ Anemia
- ☐ Bleed/Bruise easily
- Other:_____

☐ **Respiratory**
- ☐ Asthma
- ☐ COPD
- ☐ Tuberculosis

☐ **Foreign Body Sensation**

☐ **Additional Allergy Symptoms**
- ☐ Congestion
- ☐ Runny nose
- ☐ Dark circles under eyes
- ☐ Itchy/flaky skin
- Other:________________

☐ **Neurologic/Psychiatric**
- ☐ Seizures/Convulsion
- ☐ Parkinson's Disease
- ☐ Alzheimer's
- Other:________________

☐ **Musculoskeletal**
- ☐ Arthritis
- ☐ Joint replacement

☐ Skin/Problems

☐ **Cancer**
____
____

☐ **Ear/Nose/Throat**
____

Are you allergic to any medication (including Iodine)? ____Yes ____No. If yes, please list medications and reactions:____
____

Eye Surgery/Trauma: Please list: Right Eye ___________________________ Left Eye ___________________________

Surgeries/Hospitzalizations within the last 5 years:____
____

Current List of Medications (including over-the-counter):

Name/Dosage	**Name/Dosage**	**Name/Dosage**
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________

Social History: Smoking Quit Smoking (Year)________ Alcohol Use________ Occupation:________

Primary Care Physician:__________________ City:_______________ ST:_____ Phone:__________________

Patient Name:
DOB:
Patient Number:

MEDICARE ENROLLEES:

I request that payment of authorized Medicare benefits be made to either me or on my behalf to the doctor and associates of the Michigan Eyecare Institute providing my care for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the Michigan Eyecare Institute for Medicare and Medicaid Services and its agents any information needed to determine these benefits payable for related services.

____ ______________________________________

Patient's Signature Date

I request that payment of authorized Medicap benefits be made either to me or on my behalf to the doctor and associates of the Michigan Eyecare Institute providing my care for any services furnished to me by that physician. I ____ will provide all information needed to determine these benefits payable for related services.

____ ______________________________________

Patient's Signature Date

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.

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.

 Initials________________

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