Date: _____________

PATIENT INFORMATION

OFFICE USE ONLY
UPDATED Date / Initial

Last Name: ____________________________ First Name: __________________ Middle Initial: ________

How would you like to be addressed: Mr.____ Mrs.____ Ms.____ Dr.____ Other __________________

Address: __________________________________ City: _____________________________ State: ______

Zip Code: ______________ Home Phone: ___________________________

E-Mail Address: ____ Social Security #: ______-____-______

(Patient's) Employer: ____

(Patient's) Work Phone: ___________________________ (Patient's) Cell Phone:______________________

Date of Birth: _____/_____/_____ Present Age: _____ Sex: Male_____ Female_____

Spouse Date of Birth: _____/_____/_____

Mother's Maiden Name:_______________

Race (*for medical purposes*): African American_____ White_____ Hispanic_____
Native American Indian_____ Asian American_____ Other_____

Family Physician: ____
First Name Last Name
Phone: ____

Referring Doctor (if any): ____
First Name Last Name
Phone: ____

Do you see anyone else for eye care? YES___ NO___

If yes, whom: ____

Emergency Contact: ______________________________________Relationship___________________

Address:________________________________ City: ____________ State: _________ Zip Code: ______

Home Phone: _____________________________ Work Phone: _________________________________

Today's Date

____

PERSONAL HEALTH HISTORY

Name________________________________ DOB__________ Present Age______

Current Occupation ____________________________

1. Please explain your present eye health and vision condition (if known):

____

2. Do you normally wear glasses or contacts? __Yes __No
   If YES, which do you wear most of the time? ___glasses __contacts
   If YES, how old is the prescription? ______________

3. Are you currently taking medication (of any type, for any condition)? ___Yes ___No
   If YES, please list:____
   ____

4. Are you allergic to any medications? __Yes __No
   If YES, please list medication and reaction:____________________________________

4a. Are you allergic to latex? __Yes __No

5. Medical History: Check YES or NO; if YES, also note when diagnosed.

__YES __NO High Blood Presure
__YES __NO Arthritis
__YES __NO High Cholesterol
__YES __NO Lupus
__YES __NO High Blood Sugar/Diabetes
__YES __NO Migraines
__YES __NO Asthma
__YES __NO Emphysema
__YES __NO Cancer
__YES __NO Stroke

__YES __NO Chest Pain
__YES __NO Heart Rhythm Problems
__YES __NO HIV(+) or AIDS
__YES __NO Inflammatory Bowel Disease
__YES __NO Ulcers
__YES __NO Thyroid Disease
__YES __NO Heart Attack
__YES __NO Congestive Heart Failure
__YES __NO Other (please specify)
____

6. Do you have any history of eye problems or had any eye surgery? __YES __NO
   If YES, please list types and dates: ______________________________________

7. Are you pregnant or breast-feeding? __YES __NO

PLEASE TURN THIS PAGE OVER AND COMPLETE THE BACK SIDE OF THIS FORM.

Medical History Update

Date	Initial	Date	Initial	Date	Initial

8. Have you ever had any surgeries (other than your eyes), like for tonsils, appendicitis, etc.?
___YES ___NO
If YES, Please list dates and types ____
____

9. Do you have any of the following symptoms NOW?
If NO, please check box; if YES, please circle words tha apply.

___NO **Eye**: pain; blurred vision; double vision; redness; burning; itching; discharge; light sensitivity
___NO **Neuro**: dizziness; weakness; numbness; tingling; trouble speaking;
loss of balance
___NO **General**: fever; chills; weight loss; night sweats; scalp tenderness
___NO **Skin**: rash; bruising
___NO **Heart**: chest pain; rapid heartbeat
___NO **Digestive**: constipation; diarrhea; nausea; vomiting; blood in stools; black tarry stools; bowel/bladder dysfunction
___NO **Bladder**: increased urinary frequency; pain with urination
___NO **Pulmonary**: cough; shortness in breath; sputum
___NO **Muscle**: pain in joints; pain in muscles
___NO **Hematologica**l: anemia; easy bruising or bleeding; past transfusions and any reactions to them
___NO **Endocrine**: thyroid trouble; heat or cold intolerance; excessive sweating; diabetes; excessive thirst or hunger; excessive urination
__NO **Psychiatric**: nervousness; tension; mood, including depression; memory loss

10. DO you smoke cigarettes or use tobaco products? ___YES ___NO, Never have
___NO, not any longer If YES, how much/how many cigarettes per day? _______

11. Do you drink alcohol? ___YES ___NO ___OCCASIONALLY

12. Do you use recreational (non-legal) drugs? (marijuana, crack, speed, heroin, etc.)
___YES ___NO, Never have ___NO, not any longer

13. Is there a family history of the following? **(Check YES or NO, also note relationship - father, mother, etc.)**

__YES __NO CATARACTS ______________
__YES __NO GLAUCOMA _______________
__YES __NO HIGH BLOOD SUGAR/DIABETES ________________
__YES __NO RETINAL DISEASE ____________________________
__YES __NO HIGH BLOOD PRESSURE ______________________
__YES __NO MIGRAINE HEADACHES _______________________
__YES __NO OTHER _____________________________________

14. Where did you have your last physical exam?
Approximate Date ______________ Doctor’s name ____________________

____________________________ ______________
SIGNATURE OF PATIENT **DATE**

MISYS #________

SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT

1. **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to **Michigan Eye Care Specialists, P.C.** 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 or the release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. **Michigan Eye Care Specialists, P.C.** accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.
2. **MEDIGAP:** I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to **Michigan Eye Care Specialists, P.C.,** if possible or otherwise to me.
3. **RELEASE OF INFORMATION: Michigan Eye Care Specialists, P.C.** may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to **Michigan Eye Care Specialists, P.C.** for reimbursement for services rendered, and (2) any health care provider for continued patient care. **Michigan Eye Care Specialists, P.C.** may also disclose, on an anonymous basis, any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, status, or regulation.
4. **OTHER INSURANCE:** I understand that **Michigan Eye Care Specialists, P.C.** maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office and that **Michigan Eye Care Specialists, P.C.** has no contract, expressed or implied with any plan that does not appear on the list. The undersigned agrees that I am an individual obligated to pay the full charges of all services rendered to me by **Michigan Eye Care Specialists, P.C.** if I belong to a plan that does not appear on the above mentioned list.
5. **NON-COVERED SERVICES:** I understand that **Michigan Eye Care Specialists, P.C.** contracts with health care service plans (i.e., HMOs, PPOs) state items and services which are “covered” by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient’s contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient; and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with **Michigan Eye Care Specialists, P.C.** to obtain necessary health care service plan authorizations.
6. **FINANCIAL AGREEMENT:** I agree that in return for the services provided to the patient by **Michigan Eye Care Specialists, P.C.**, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to **Michigan Eye Care Specialists, P.C.** for payment. If an account is sent to any attorney for collection, I agree to pay collection expenses and reasonable attorney’s fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged a service fee. Any benefits of any type under any policy of insurance insuring the patient or any other party liable to the patient is hereby assigned to **Michigan Eye Care Specialists, P.C.** If co-payments and/or deductibles are assigned by my insurance company or health plan, I agree to pay them to **Michigan Eye Care Specialists, P.C.** However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.
7. **DIVORCED PARENTS:** We do not second party bill. The parent bringing the child to our facility will be responsible for required co-payments, deductibles, etc. at the time of service.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

________________________________ ________________________________
Patient or Guardian Name **(print)** Medicare Number (as applicable)

________________________________ ________________________________
Patient or Guardian**Signature Date

**If an authorization is signed by an individual’s personal representative, the representative’s authority is based on:
____e.g., state law, court order, etc.)

MISYS #________

APPROVED PARTICIPANTS OF CARE

Patient Name:____
Print

Medical Record Number:__________________

1. ___________________________________ ___________________________
Name (Print) Relationship

2. ___________________________________ ___________________________
Name (Print) Relationship

3. ___________________________________ ___________________________
Name (Print) Relationship

4. ___________________________________ ___________________________
Name (Print) Relationship

5. ___________________________________ ___________________________
Name (Print) Relationship

I authorize MECS to share my health information with the above-named people, only as necessary, to facilitate my care. I will inform MECS if I ever wish to add or delete individuals from this list.

_____________________________________ ______________________
Patient Signature Date

MISYS #________

NOTICE OF PRIVACY PRACTICES
For
Michigan Eye Care Specialists, P.C. and
Michigan Eye Care Optical, L.L.C.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our goal is to take appropriate steps to attempt to safeguard any medical or other personal information that is provided to us. The Privacy Rule under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires us to: (i) maintain the privacy of medical information provided to us; (ii) provide notice of our legal duties and privacy practices; and (iii) abide by the terms of our Notice of Privacy Practices currently in effect.

WHO WILL FOLLOW THIS NOTICE

- **This notice describes the practices of our employees and staff as well as our affiliates and business associates. This notice applies to each of these individuals, entities, sites and locations. In addition, these individuals, entities, sites and locations may share medical information with each other for treatment, payment and health care operation purposes described in this notice.**

INFORMATION COLLECTED ABOUT YOU

In the ordinary course of receiving treatment and health care services from us, you will be providing us with personal information such as:

- Your name, address, phone number, social security number and e-mail address.
- Information relating to your medical history.
- Your insurance information and coverage.
- Information concerning your doctor, nurse or other medical providers.

In addition, we will gather certain medical information about you and will create a record of the care provided to you. Some information also may be provided to us by other individuals or organizations that are part of your "circle of care" – such as the referring physician, your other doctors, your health plan, and close friends or family members.

MISYS #________

HOW WE MAY USE AND DISCLOSE INFORMATION ABOUT YOU

We may use and disclose personal and identifiable health information about you for a variety of purposes. All of the types of uses and disclosures of information are described below, but not every use or disclosure in a category is listed.

Required Disclosures. We are required to disclose health information about you to the Secretary of Health and Human Services, upon request, to determine our compliance with HIPAA and to you, in accordance with your right to access and right to receive an accounting of disclosures, as described below.

For Treatment. We may use health information about you in your treatment. For example, we may use your medical history, such as any presence or absence of diabetes, to assess the health of your eyes.

For Payment. We may use and disclose health information about you to bill for our services and to collect payment from you or your insurance company. For example, we may need to give a payer information about your current medical condition so that it will pay us for the eye examinations or other services that we have furnished you. We may also need to inform your payer of the treatment you are going to receive in order to obtain prior approval or to determine whether the service is covered.

For Health Care Operations. We may use and disclose information about you for the general operation of our business. For example, we sometimes arrange for auditors or other consultants to review our practices, evaluate our operations, and tell us how to improve our services. Or, for example, we may use and disclose your health information to review the quality of services provided to you.

Public Policy Uses and Disclosures. There are a number of public policy reasons why we may disclose information about you which are described below.

We may disclose health information about you when we are required to do so by federal, state, or local law.

We may disclose protected health information about you in connection with certain public health reporting activities. For instance, we may disclose such information to a public health authority authorized to collect or receive PHI for the purpose of preventing or controlling disease, injury or disability, or at the direction of a public health authority, to an official of a foreign government agency that is acting in collaboration with a public health authority. Public health authorities include state health departments, the Center for Disease Control, the Food and Drug Administration, the Occupational Safety and Health Administration and the Environmental Protection Agency, to name a few.

We are also permitted to disclose protected health information to a public health authority or other government authority authorized by law to receive reports of child abuse or neglect. Additionally, we may disclose protected health information to a person subject to the Food and Drug Administration's power for the following activities: to report adverse events, product defects or problems, or biological product deviations; to track products; to enable product recalls; repairs or replacements; to conduct post marketing surveillance. We may also disclose a patient's health information to a person who may have been exposed to a communicable disease or to an employer to conduct

an evaluation relating to medical surveillance of the workplace or to evaluate whether an individual has a work-related illness or injury.

We may disclose a patient's health information where we reasonably believe a patient is a victim of abuse, neglect or domestic violence and the patient authorizes the disclosure or it is required or authorized by law.

We may disclose health information about you in connection with certain health oversight activities of licensing and other health oversight agencies which are authorized by law. Health oversight activities include audit, investigation, inspection, licensure or disciplinary actions, and civil, criminal, or administrative proceedings or actions or any other activity necessary for the oversight of: 1) the health care system; 2) governmental benefit programs for which health information is relevant to determining beneficiary eligibility; 3) entities subject to governmental regulatory programs for which health information is necessary for determining compliance with program standards; or 4) entities subject to civil rights laws for which health information is necessary for determining compliance.

We may disclose your health information as required by law, including in response to a warrant, subpoena, or other order of a court or administrative hearing body or to assist law enforcement identify or locate a suspect, fugitive, material witness or missing person. Disclosures for law enforcement purposes also permit use to make disclosures about victims of crimes and the death of an individual, among others.

We may release a patient's health information (1) to a coroner or medical examiner to identify a deceased person or determine the cause of death and (2) to funeral directors. We also may release your health information to organ procurement organizations, transplant centers, and eye or tissue banks, if you are an organ donor.

We may release your health information to workers' compensation or similar programs, which provide benefits for work-related injuries or illnesses without regard to fault.

Health information about you also may be disclosed when necessary to prevent a serious threat to your health and safety or the health and safety of others.

We may use or disclose certain health information about your condition and treatment for research purposes where an Institutional Review Board or a similar body referred to as a Privacy Board determines that your privacy interests will be adequately protected in the study. We may also use and disclose your health information to prepare or analyze a research protocol and for other research purposes.

If you are a member of the Armed Forces, we may release health information about you for activities deemed necessary by military command authorities. We also may release health information about foreign military personnel to their appropriate foreign military authority.

We may disclose your protected health information for legal or administrative proceedings that involve you. We may release such information upon order of a court or administrative tribunal. We may also release protected health information in the absence of such an order and in response to a discovery or other lawful request, if efforts have been made to notify you or secure a protective order.

If you are an inmate, we may release protected health information about you to a correctional institution where you are incarcerated or to law enforcement officials in certain situations such as where the information is necessary for your treatment, health or safety, or the health or safety of others.

Finally, we may disclose protected health information for national security and intelligence activities and for the provision of protective services to the President of the United States and other officials or foreign heads of state.

Our Business Associates. We sometimes work with outside individuals and businesses that help us operate our business successfully. We may disclose your health information to these business associates so that they can perform the tasks that we hire them to do. Our business associates must promise that they will respect the confidentiality of your personal and identifiable health information.

Disclosures to Persons Assisting in Your Care or Payment for Your Care. We may disclose information to individuals involved in your care or in the payment for your care. This includes people and organizations that are part of your "circle of care" – such as your spouse, your other doctors, or an aide who may be providing services to you. We may also use and disclose health information about a patient for disaster relief efforts and to notify persons responsible for a patient's care about a patient's location, general condition or death. Generally, we will obtain your verbal agreement before using or disclosing health information in this way. However, under certain circumstances, such as in an emergency situation, we may make these uses and disclosures without your agreement.

Appointment Reminders. We may use and disclose medical information to contact you as a reminder that you have an appointment or that you should schedule an appointment.

Treatment Alternatives. We may use and disclose your personal health information in order to tell you about or recommend possible treatment options, alternatives or health-related services that may be of interest to you.

Fundraising. We may use your protected health information to contact you in an effort to raise funds for our operations.

OTHER USES AND DISCLOSURES OF PERSONAL INFORMATION

We are required to obtain written authorization from you for any other uses and disclosures of medical information other than those described above. If you provide us with such permission, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose personal information about you for the reasons covered by your written authorization, except to the extent we have already relied on your original permission.

INDIVIDUAL RIGHTS

You have the right to ask for restrictions on the ways we use and disclose your health information for treatment, payment and health care operation purposes. You may also request that we limit our disclosures to persons assisting your care or payment for your care. We will consider your request, but we are not required to accept it.

You have the right to request that you receive communications containing your protected health information from us by alternative means or at alternative locations. For example, you may ask that we only contact you at home or by mail.

Except under certain circumstances, you have the right to inspect and copy medical, billing and other records used to make decisions about you. If you ask for copies of this information, we will charge you a fee for copying and mailing.

If you believe that information in your records is incorrect or incomplete, you have the right to ask us to correct the existing information or add missing information. Under certain circumstances, we may deny your request, such as when the information is accurate and complete.

You have a right to receive a list of certain instances when we have used or disclosed your medical information. We are not required to include in the list uses and disclosures for your treatment, payment for services furnished to you, our health care operations, disclosures to you, disclosures to give us authorization to make and uses and disclosures before April 14, 2003, among others. If you ask for this information, there will be a charge.

You have the right to a copy of this notice in paper form. You may ask us for a copy at any time. You may also obtain a copy of this form at our web site.

To exercise any of your rights, please contact us in writing at Michigan Eye Care Specialists, P.C.; 702 W. Lake Lansing Road; East Lansing, MI 48823; Attn: Linda Snell. When making a request for amendment, you must state a reason for making the request.

CHANGES TO THIS NOTICE

We reserve the right to make changes to this notice at any time. We reserve the right to make the revised notice effective for personal health information we have about you as well as any information we receive in the future. In the event there is a material change to this notice, the revised notice will be posted. In addition, you may request a copy of the revised notice at any time.

COMPLAINTS/COMMENTS

If you have any complaints concerning our privacy practices, you may contact the Secretary of the Department of Health and Human Services at 200 Independence Avenue; S.W.; Room 509F; HHH Building; Washington, D.C. 20201 (e-mail: ocrmail@hhs.gov). You also may contact us at Michigan Eye Care Specialists, P.C.; 702 W. Lake Lansing Road; East Lansing, MI 48823; (517) 332-6523; Attn: Linda Snell.

YOU WILL NOT BE RETALIATED AGAINST OR PENALIZED BY US FOR FILING A COMPLAINT.

MISYS #________

To obtain more information concerning this notice, you may contact our Privacy Officer, Linda Snell at Michigan Eye Care Specialists, P.C.; 702 W. Lake Lansing Road; East Lansing, MI 48823; or at (517) 332-6523.

This notice is effective as of **April 14, 2003.**

Copyright © 2001 Arent Fox Kintner Plotkin & Kahn, PLLC. All rights reserved.

MISYS #________

Michigan Eye Care Specialists, P.C.
and
Michigan Eye Care Optical, L.L.C.
Privacy Policy
Acknowledgment of Receipt

I, ____________________________________, acknowledge that I have been offered a copy of the Michigan Eye Care Specialists, P.C. and Michigan Eye Care Optical, L.L.C., Privacy Notice. A copy of this policy is available at any time upon request.

______________________________________ ____________

Patient Signature **Date**

☐ **Patient was offered a copy of the Privacy Notice but declined to sign acknowledgment.**