HURON OPHTHALMOLOGY, P.C.

Date: _____

PATIENT INFORMAITON

Patient Name: _____ Date of Birth: _____

Social Security (needed for Prescriptions & Insurance billing): _____

Address: _____

City: _____ State: _____ Zip code: _____ County: _____

Age: _____ Martial Status □ Single □ Married □ Other Gender: □ Male □ Female

Home Phone: _____ Cell Phone: _____ Preferred Phone: □ Home □ Cell

Occupation: _____ Employer or School: _____

Patient's Preferred Language: _____

Race:
□ African American/Black
□ American Indian/Alaskan Native
□ Caucasian/White
□ Asian
□ Native Hawaiian/Pacific Island
□ Declined to Provide

Ethnicity:
□ Hispanic
□ Non-Hispanic or Latino
□ Declined to Provide

EMERGENCY CONTACT

Emergency Contact Name: _____ Relationship: _____

Emergency Home Phone: _____ Emergency Work Phone: _____

REFERRING DOCTORS

Referring Doctor: _____ Phone: _____

Address: _____ Fax: _____

Primary Care Physician: _____ Phone: _____

Address: _____ Fax: _____

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 APPLICABLE)

If patient is being seen due to injury, please complete the following:

□ Injury at work: Date of injury: _____ Claim #: _____

Employer Address: _____

Case Worker/Adjuster Name: _____ Phone: _____

□ Auto Accident: Date of Accident: _____ Claim#: _____

Case Worker/Adjuster Name: _____ Phone: _____

HURON OPHTHLAMOLOGY, P.C.

AUTHORIZATION FORM
FOR OTHER USES OF PROTECTED HEALTH INFORMATION (PHI)

Our notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. On occasion, the patient and the Practice may want to use PHI for reasons other than treatment, payment, and health care operations. This form summarizes the anticipated use of information about you for which this **authorization is required.** The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

I, _____ (Patient), give Huron Ophthalmology, P.C. permission to disclose the details of my medical record to the following individuals:

NAME	RELATIONSHIP
_____	_____
_____	_____
_____	_____

Please check off the following details which may be disclosed to the individuals listed above:

___ Any and all items related to Huron Ophthalmology, P.C.

___ Exam dated _____

___ Medications

___ Billing

___ Or the following information: _____

_____

Purpose of disclosure (please record the purpose of the disclosure or check patient request):

□ Patient Request

□ Other (please specify): _____

This authorization is approved until termination of patient's relationship with the practice.

By signing this form, you authorize the Practice to use and disclose protected health information about you for the reasons stated above. You have the right to revoke this authorization at any time, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior authorization. Submit your revocation to the Privacy Officer of the Practice.

_____ _____

Signature of Patient Date

_____

Printed Name of Patient

_____

Witnessed by Huron Ophthalmology, P.C. Employee

For office use only: MRN _____ Information Entered _____ Staff initials_____

HURON OPHTHLAMOLOGY, P.C.
5477 W. CLARK RD.
YPSILANTI, MI 48197

HURON OPHTHALMOLOGY, P.C.
AUTHORIZATION FOR RECORD RELEASE AND PAYMENT

1. AUTHORIZATION FOR RELEASE OF PATIENT RECORDS

I, _____ authorize Huron Ophthalmology, P.C. to release information contained in my patient records to the referring physician identified in my patient information form and or to any other physician or health care professional/entity to whom I may be referred to by Huron Ophthalmology, P.C.

_____ _____
Signature of patient or patient's representative Date

_____ _____
Printed name of patient or patient's representative Relationship to patient if person other than Patient is signing

2. AUTHORIZATION FOR PAYMENT

I authorize the release of any protected health information (PHI) necessary to process claims for payment. I hereby authorize payment of insurance benefits, including Medicare/Medicaid benefits, to be made directly to Huron Ophthalmology, P.C. I understand that I am financially responsible to pay Huron Ophthalmology, P.C. (including physician, optometrist, optical shop, and diagnostic testing) for services not covered or payable by my insurance carrier.

_____ _____
Signature of patient or patient's representative Date

_____ _____
Printed name of patient or patient's representative Relationship to patient if person other than Patient is signing

3. LIFETIME MEDICARE AUTHORIZATION

I request that payment of authorized Medicare and/or Medicaid benefits be made either to me or on my behalf to Huron Ophthalmology, P.C. or its agent, for any services furnished to me by that supplier. I authorize any holder of hospital or medical information about me to release to the Social Security Administration Centers for Medicare & Medicaid (CMS) or its intermediaries or carries any information of documentation needed to determine these benefits or benefits payable for related services. I permit a copy of this authorization to be used in place of the original. I understand this authorization may be used by Huron Ophthalmology, P.C. for all services in the future until such time as I revoke this authorization in writing (Section 1128B of the Social Security Act and 31 U.S.C. 381-3812 provides penalties for withholding this information).

_____ _____
Signature of patient or patient's representative Date

_____ _____
Printed name of patient or patient's representative Relationship to patient if person other than Patient is signing

Huron Ophthalmology, P.C.
5477 W Clark Rd.
Ypsilanti, MI 48197

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I received a copy of Huron Ophthalmology, P.C.'s Notice of Privacy Practices.

Patient Name _____

_____

Patient (or Personal Representative) Signature

_____

Relationship to patient if person signing is not the patient

_____

Date

Documentation of Failure to Obtain Signed Acknowledgement

On _____, 20___, Huron Ophthalmology, P.C. presented this Acknowledgement of Receipt of Notice of Privacy Practices Form to _____(patient). The patient refused to provide a signature when requested.

Huron Ophthalmology, P.C.

FINANCIAL POLICY

The purpose of this document is to inform our patients about Huron Ophthalmology, P.C.'s Financial Policy. We hope this reduces the confusion and misunderstandings. If you have questions about the policy, please ask to speak with a member of our Customer Service Team. We are dedicated to providing the best possible care and services to you and regard your understanding of our financial policy as an element of your care and treatment.

1. Payment for all services provided by our practice is due in full at the time services are rendered. Exclusions to this policy are those patients who are a member of a health care organization that we have a participating agreement with, such as Medicare, Blue Cross Blue Shield, and others. We will bill your primary insurance plans for which we have an agreement and will only require you to pay the authorized co-payment, deductible or non-covered services at the time of service.
2. Whenever you are having a procedure or surgery performed in the hospital, it is important to check if the facility also participates with your insurance company. It is the patient's responsibility to make this determination.
3. If you are a member of a health care organization that Huron Ophthalmology does not have a participation agreement with, we will prepare and submit a claim for you. This means your insurer will send the payment directly to you and the charges for your care are due at the time service was rendered.
4. Huron Ophthalmology, P.C. will charge $25.00 whenever you no show or have a late cancellation and a $50.00 charge for procedure patients. In order to avoid such charges, it is important that you call a member of our scheduling team to cancel your appointment with a minimum of 24 hours prior to your appointment. This courtesy allows other patients who are waiting for an appointment to use this time slot.
5. Medicare patients are responsible for their co-payments and any items deemed Medically Unnecessary by Medicare. In the event your health plan determines services to be "not covered" you will be responsible for the complete charge.
6. If you are unable to pay for the visit at the time of service, please call our office prior to the appointment to arrange a payment plan.
7. For all service rendered to minor patient, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.
8. Huron Ophthalmology, P.C. accepts cash, personal checks, MasterCard, Visa, and Discover.
9. Be prepared to pay for all co-pays, deductibles, and non-covered services the same day as your appointment. There is a $15.00 billing fee if not paid in full at the time of service. If you are unable to pay for the visit at the time of service, please call our office prior to your appointment to arrange a payment plan.
10. A $15.00 fee will be assessed to the account for every check returned to Huron Ophthalmology, P.C. for insufficient funds.
11. Refunds will be issued to patients on a monthly basis. Refunds will be issued in the form of a check to those accounts paid with cash or check (check must have cleared the bank first). Any payments made by credit card will be refunded directly back to the patients' credit card.
12. Huron Ophthalmology, P.C. reserves the right to turn any patient over to collections if it is deemed that the account has been in default of the payment obligations or compliance of this policy. It is understood and agreed that Huron Ophthalmology, P.C. shall recover all costs and expenses incurred in the collection of any such delinquent amounts.
13. There are charges for the completion of every form we are asked to complete by patient, insurance companies, etc. As an example, some of these forms would be: driver's license forms, housing forms, disability forms, life insurance, etc. The charges for these forms start at $15.00 and goes up depending on the form needed.

I have read and understand the above Financial Policy of Huron Ophthalmology, P.C. I also understand and agree that such terms may be amended from time-to-time by Huron Ophthalmology, P.C.

Signature _____ **Date** _____

Huron Ophthalmology, P.C.
5477 W. Clark, Rd.
Ypsilanti, MI 48197

To Our Patients Important Payment Information About your Eye Exam and the Refraction

One of the most important parts of your eye exam today is the REFRACTION. The REFRACTION is a test used to determine the best possible visual acuity and function of your eye, which is essential medical information for us to have as we assess the health of your eyes and in determining whether you can be helped in any way by new glasses, contact lens prescription, or surgery. This test is necessary for prescribing corrective lenses for glasses or surgery, and we cannot provide you with any eyeglasses without this part of the exam. Even though contact lens prescriptions involve a refraction, there are more additional measurements required, therefore the contact lens prescriptions are a separate fee.

The REFRACTION is NOT a covered service by Medicare, Medicaid and most other insurance companies. The insurance companies consider this service/test as routine and a totally separate service and charge from the dilated eye exam. Unfortunately, this places the responsibility for this charge in addition to any other patient costs (deductible, co-payments) as defined by your medical insurance coverage, on the patient. If we believe that your plan may cover the refraction charge, we will file the charge with your health insurance plan. The charge for a refraction is $50.00 and will be charged to the patient, in addition to any deductibles and/or co-payments your plan may require.

Should your plan pay us instead of reimbursing you for the refraction, we will reimburse you accordingly.

I have read the above information and understand that the refraction is a noncovered service. I accept full financial responsibility for the cost of this service and I understand it is due at the time of service. I further understand and accept full financial responsibility for any co-payments, coinsurance, and/or deductibles that I may have and I understand they are due at the time of service.

If I **decline** this service, I understand that a new glasses prescription will not be made available to me, as glasses prescriptions expire yearly.

_____ _____

Patient's Name Date

_____ _____

Patient's Signature Staff Witness