



OAKLAND
OPHTHALMIC
SURGERY, P.C.

Patient Information:

Patient Name (Last, First, MI): _____
Birthdate: _____ Social Security #: _____ Gender: M F
Home Address: _____ City _____ State _____ Zip _____
Home #: _____ Work #: _____
Cell #: _____ ER contact Name & phone #: _____
E-mail: _____

Marital Status: Single Married Widow Divorced

Primary Care Physician _____ Office Phone: _____

Referring Physician _____ Office Phone: _____

Meaningful use information:

Primary Language _____ Race _____ Ethnicity _____

If patient is a minor:

Guardian Name: _____ Birthdate _____ Social Security # (last 4) _____

Signature _____ Date _____

E-prescribing allows physicians and other medical practitioners to write and send prescriptions to a participating pharmacy electronically, through a secure internet connection, instead of using handwritten or faxed notes or calling in prescriptions. Please provide your pharmacy information below.

PHARMACY Name: _____

CITY Pharmacy is in: _____

PHARMACY Phone Number: _____

PHARMACY Crossroads: _____

Vision Insurance VS Medical Insurance

What is the difference? We hope we can clarify this question for you.

Your vision insurance is a “rider” that either you or your employer purchases to receive coverage for a routine eye exam and glasses or contact lenses. Medical insurance is intended to cover services when a medical condition exists.

How do I know if my visit is medical or vision?

Your vision insurance would apply for a routine eye examination if you:

- Have no known problems with your eyes except for needing new glasses.

AND/OR

- Were not referred by another physician.

AND/OR

- Your previous eye examinations by Dr. Erickson, Dr. Page, or Dr. Jancevski did not show any medical conditions.

If the above does not apply then we need to address the medical condition and use your medical insurance.

Examples of medical conditions: Cataracts, glaucoma or suspicion of glaucoma, macular degeneration, implants, red eyes, tearing, irritation, pain, etc.

Health and Social History

Patient Name _____ Birth date _____

Do you have or have you had any of the following? (please check)

- | | | |
|---|---|---|
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Diabetes- Type 1__Type 2__ | <input type="checkbox"/> Myasthenia Gravis |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Alzheimer's/Dementia | <input type="checkbox"/> Enlarged Prostate | <input type="checkbox"/> Parkinson's |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Rosacea |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sarcoid |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Herpes S Virus | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Auto Immune Disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Sinus |
| <input type="checkbox"/> Bleeding Tendencies | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Sjogren's |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Carotid Artery Disease | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Thyroid Hyper/Hypo |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Lupus | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Crohn's | <input type="checkbox"/> MRSA | <input type="checkbox"/> Wegner's |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Multiple Sclerosis (MS) | <input type="checkbox"/> Other _____ |

Have you had any past eye Surgery/ Trauma: Please List:

Right Eye: _____ Left Eye: _____

Surgeries/ hospitalizations within the last 5 years: _____

Social History:

Tobacco use: Current Smoker _____ Former Smoker _____ Never Smoked _____

Alcohol use: Current Drinker _____ Former Drinker _____ Never Drinker _____

Average drinks number of drinks: _____ per _____ (day, week or month)

Do you currently drive a Car? Yes _____ No _____

Do you live alone? Yes _____ No _____

Family History (Immediate Family)

DISEASE/CONDITION	NO	YES	RELATIONSHIP TO YOU
Cataract			
Diabetes			
Glaucoma			
Macular Degeneration			

Primary Care Physician _____ **Phone** _____

Endocrinologist _____ **Phone** _____

Rheumatologist _____ **Phone** _____

Today's Date _____

AUTHORIZATION FOR DISCLOSURE OF TREATMENT

This signature page is designed for you to establish limitations on what information we can share with people other than your insurance company or Drs. who coordinate your care. If you have certain family members or caregivers that normally assist you in either your health care decisions or financial decisions, you may wish to include them on this form. If you do not authorize anyone on this form, please be aware that we will not be allowed to answer any questions regarding your care, including billing, to anyone but *you* (including your spouse, siblings, adult children, and caregivers).

I authorize the person(s) named below to discuss my care in my absence and obtain my medical records if necessary (this does not include doctors who are involved in my care). I understand this authorization is in effect unless I revoke the authorization in writing.

Authorized Individuals:

Name	Relationship	Phone

Specific information to be disclosed (check all that apply):

- Office Notes
- Diagnostic/Imaging
- Financial/Billing
- Other _____

PATIENT SIGNATURE

DATE

Form must be signed and dated each year.



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NOTICE OF PRIVACY PRACTICES

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

At the Oakland Ophthalmic Surgery, we believe that your health information is personal. We keep records of the care and services that you receive at our facilities. We are committed to keeping your health information private, and we are also required by law to respect your confidentiality.

This Notice describes the privacy practices of Oakland Ophthalmic Surgery. This Notice applies to all of the health records that identify you and the care you receive at Oakland Ophthalmic Surgery. If you are under 18 years of age, your parents or guardian must sign for you and handle your privacy rights for you. We are legally required to give you this Notice and to follow the terms of the Notice that is currently in effect.

Please review it carefully.

- Oakland Ophthalmic Surgery may disclose your health and/or medical information to treating health care professionals including but not limited to: physicians, nurses, lab technicians, and pharmacists.
- Oakland Ophthalmic Surgery will disclose your health and/or medical information when we are required to do so by Federal, State, or Local Law.
- Oakland Ophthalmic Surgery may disclose your health and/or medical information to third party payers, Insurance companies, and/or billing companies in order to receive payment for the services you received.
- Oakland Ophthalmic Surgery may confirm appointments, leave a medically related message, or leave a message related to your financial account on your home or cell phone, answering machine and/or voicemail, or directly with a person at your home.
- You have the right to inspect and obtain a copy of your health and/or medical information. This request must be in writing, there is a reasonable fee for copying the records.

I understand that the statements above are only a summary of Oakland Ophthalmic Surgery's Privacy Practices. I have been offered to retain my own complete copy of the Privacy Practices as well as the opportunity to review an office copy of the complete version.

Signature of patient _____ Date _____
Guardian must sign for minor

Witness _____ Date _____



**Consent to Treat • Consent to Communications • HIPAA • Patient
Financial Responsibility • Assignment of Benefits**

Patient Name (Please print)

Date of Birth (MM/DD/YYYY)

Thank you for trusting us with your eye care needs. Our team is committed to providing you with expert, compassionate medical and vision care. Please read through this document, ask us any questions you may have, and sign at the bottom. Please understand that payment of your bills is considered part of your treatment. We are happy to provide you with a copy of this document upon request.

General Consent to Care I, the undersigned, for myself, a minor child, or another person for whom I have authority to sign, hereby consent to medical and vision care and treatment, as ordered by a provider, which such medical or vision care and treatment is provided through my provider's practice, which is part of the Oakland Ophthalmic Surgery network (the "Practice"). This consent includes my consent for all medical and vision services rendered under the general or specific instructions of the provider. I agree and acknowledge that Oakland Ophthalmic Surgery is not liable for the actions or omissions of, or the instructions given by the provider(s) who treat me while I am a patient. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me as to the result of treatments or examinations.

I understand that I have the right to discuss the treatment plan with my physician about the purpose, potential risks, and benefits of any tests ordered for me. If I have concerns regarding any test or treatment recommended by my provider, I understand that am encouraged to ask questions.

HIPAA Privacy Policy I acknowledge that the Practice has made available to me the "Notice of Privacy Practices" in compliance with current HIPAA regulations.

Consent to Call, Email & Text By signing below I agree and authorize Oakland Ophthalmic Surgery (and entities or individuals working on Oakland Ophthalmic Surgery behalf) to deliver or cause to be delivered calls, text messages, and/ or emails using an automatic telephone dialing system or an artificial or prerecorded voice at the numbers(s) and /or email address(s) I have provided to schedule an appointment, remind me I am due for an appointment, remind me of an upcoming appointment, contact me that my eyewear or contact lenses are ready, contact me regarding outstanding payments or bills due, contact me about my account, and/or provide me messages containing advertisements or telemarketing. I understand that I may be charged by my phone provider or a third party provider for such communications and that I can revoke my consent at any time. I understand that I am not required to provide such an authorization as a condition of purchasing any property, goods or services from Oakland Ophthalmic Surgery.



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Insurance We participate with most insurance plans, including Medicare. If the undersigned or the patient for whom the undersigned has authority to sign is insured by a plan we accept but does not have an up-to-date insurance card, payment in full for each visit is required until coverage can be verified. A quote of benefits is not a guarantee of benefits or payment. Charges not covered by insurance company or benefit plan, as well as any co-payments, deductibles, and co-insurance amounts, are the undersigned's responsibility. If the undersigned has questions about what the applicable insurance or benefit plan will cover, please contact the insurance or benefit plan directly. Ultimately, it is the undersigned's responsibility to understand the applicable coverage. Therefore, we strongly encourage the undersigned to check with your insurance company regarding coverage prior to any office visit or procedure.

Referrals Some insurance plans require the patient to obtain a referral for services. Please review your insurance policy to see if a referral is required prior to the office visit. If a required referral is not on file at the time of the visit, the appointment could be rescheduled or the patient will be responsible for all charges incurred on this date.

Assignment of Benefits I request that payment of authorized insurance benefits for Medicare, Medicaid, and other health insurance and vision benefit plans be paid directly to the Practice for all medical, vision, surgical, medication, diagnostic testing, laboratory services, supplies, and equipment provided to me during all courses of treatment and care provided by the Practice. I also understand and agree this Assignment of Benefits will continue for as long as I am being treated or cared for by the Practice and will constitute a continuing authorization, maintained on file, which will authorize and allow for direct payment to the organization of all applicable and eligible coverage benefits for all subsequent and continuing treatment, services, supplies, and/or care provided. I also realize that I am responsible for paying any non-covered services, co-payments, deductibles, or co-insurance amounts due.

Patient Financial Responsibility I understand that I am financially responsible to the Practice for any charges not covered by health care or vision plan benefits. It is my responsibility to notify the Practice of any changes in my health care or vision coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the Practice and/or my health care insurer or vision benefit plan if the submitted claims or any part of them are denied for payment. All copays and non-covered services are expected to be paid at the time of service. In some cases, deductibles and co-insurance will be collected prior to service.

I understand that by signing this form, I am accepting financial responsibility as explained above for payment for all services and products received.

This consent and authorization will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services. I certify that I have read and understand the above statements.

Patient/Legal Representative Signature

Date



Authorization to Disclose Information to Those Involved in My Care

I authorize Oakland Ophthalmic Surgery to disclose or provide my Protected Health Information including, but not limited to:

- Health and Billing Information
- Appointment times & Dates
- Information regarding behavioral and mental health services, substance use disorder treatments, and communicable diseases such as sexually transmitted diseases and human immunodeficiency virus (HIV infection, Acquired Immune Deficiency Syndrome or AIDS related complex) may be shared unless written exclusion is on file.

I understand the person(s) I list to Authorize to Disclose Information to those Involved in my Care, will also be listed as my emergency contact. If this information is to change, the front desk will need to be notified.

To the following people: (please print full name)

Name: _____

Relationship: _____ Phone number: _____

Name: _____

Relationship: _____ Phone number: _____

Name: _____

Relationship: _____ Phone number: _____

Is there any protected health information you would like to exclude from disclosure to the parties listed above? If yes, fill in here: _____

This authorization has No Expiration unless revoked or terminated—in writing—by the patient or patient's personal representative.

Patient/Legal Representative Signature

Date

This form replaces all prior disclosure authorizations as of the date above.



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Consent to Obtain Patient Medication History

Patient medication history is a list of prescriptions that healthcare providers have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history.

I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

By signing this consent form you are giving your healthcare provider permission to collect and share your pharmacy and your health insurer information about your prescription that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health issues such as depression.

Patient/Legal Representative Signature

Date

Oakland Ophthalmic Surgery

MEDICAL & VISION EXAMS • REFRACTIONS • PRESCRIPTION RELEASE

The type of care you need will determine if medical or vision insurance is billed

- Medical insurance covers medical eye exams relating to any *health issues* affecting your eyes.
- Vision insurance covers routine eye exams specific to *how your eyes see* with glasses and/or contact lenses.

I understand that my medical coverage must be billed if my visit relates to the discovery or treatment of an eye disease, injury, or other issues that are outside the scope of a routine eye exam.

We will check your insurance benefit eligibility and make every attempt to help you understand and make the most of your benefits. It is important to understand that things can change between the eligibility check and the actual payment of the claim. For example, changes in insurance, lapse of time, new benefit years, claims that arrive to the payer after eligibility was checked, and purchases made between checking eligibility and placing an order for glasses or contacts. A quote of benefits is not a guarantee of benefits or payment. **Charges not covered by your insurance company or benefit plan, as well as any co-payments, deductibles, and co-insurance amounts, are your responsibility.**

If you have questions, please call our billing department direct at 248-644-7119.

What is a refraction? "Which is better, 1 or 2?" The refraction is the test done by your eye doctor to determine if corrective lenses will help you see better. Most medical insurances consider this a non-covered benefit. If your insurance company does not cover your refraction, you will be asked to pay a fee of \$50.

I understand that a contact lens fitting is required in addition to my complete vision exam to determine my contact lens prescription. This fitting involves a management fee, ranging from \$45 to \$250, depending on the complexity of the fit. I also understand that the contact lens fitting process may take more than one visit. I further understand that finalization of the contact lens fitting process often involves my verbal acknowledgement of successful wear, and I may provide this acknowledgement over the phone.

I understand that my eye doctor is required by the Federal Trade Commission to provide me with a copy of my prescription at the conclusion of my exam or contact lens fitting process, whether or not I desire it or ask for it.

Once a final prescription has been determined, I will receive a copy of my prescription either hard copy or via email. If I elect to receive my prescription hard copy, I understand that this may involve an additional visit to the office if my prescription is finalized over the phone.

Please check the following ways in which you prefer to receive copies of your prescriptions:

- Hard Copy
- Email _____ (please provide email address)

Patient or Guarantor signature _____ **Date** _____
For patients who are minors, signature of parent or legal guardian