Instructions.

Dear Patient,

We are delighted that you have selected us to be your eye doctors. We will do our best to live up to your expectations.

Our New Patient Registration package contains two forms: the "Patient Registration form" and the "History form". Please complete them and bring them with you on your appointment day. The "Payment Policy for Office Visits" and the "Welcome to Our Office" are for your information only; no need to bring them in.

To see/print the map to our office click "Map" on the Home page (in the left lower corner).

If you have specific concerns about your eyes, check the Frequently Asked Questions (FAQ) accessible from our Home page. There is much practical information there.

If you are coming for a new prescription for glasses or contact lenses, remove your current contact lenses and wear eyeglasses for two days before coming in.

On the day of your appointment:

- Take all medications according to your regular schedule
- Please bring with you:
    - Completed Patient Registration and History forms.
    - Referral form from your primary care doctor (if required by insurance).
    - List of medications you are using; including eyedrops.
    - Any previous medical eye record in your possession.
    - Prescription glasses you are currently using.
    - Sunglasses if you are going to be driving yourself home.
    - Personal identification document (Driver's license or similar)
    - All insurance cards you have (Medicare, other medical, vision plans)
    - Please come prepared to pay the co-pay and deductible at time of service; we accept cash, local bank checks and VISA, MasterCharge, AmEx and Discovery credit cards. Avoid the extra $15 administrative fee for late co-pay payment by paying on day of service (see "Payment Policy for Office Visits").

After you register, a technician will do a battery of initial tests. Some are high tech tests which you may not had before. They help us to better assess the condition of your eyes. There is no additional charge for these tests. Patients with symptoms of dry eye (see "Dry and Tearing Eye" under FAQ on Home page) may need the TearLab test. It is best to do the test before dilating eyedrops are instilled. There is a fee for this test. Before we do it, the technician will explain it to you and you can decide to skip the test if you so wish.

After the tests, dilating drops are administered to most (but not all) patients. It may take up to 30 minutes for your eyes to dilate properly. Once dilatation is achieved you will be seen by the doctor. We suggest that you plan to spend at least 2 hrs at the office.

If you cannot make it to your appointment please let us know as soon as you become aware of it (see "No show fees" in the attached "Payment Policy for Office Visits").

Southland Eye Clinic, P.C.
15055 Plaza South Drive, Taylor, Michigan, 48180
Phone:734-287-2666 Fax: 734-287-3864

Patient Registration Form

Patient Name _____ Date of birth: _____ Age:_____ Today's date:_____

Street/Apt #:_____City:_____ State:____ ZIP: _____

Home phone:_____ Cell phone: _____ Bus. phone: _____

SS #: Are you: ()Male () Female; ()Married ()Single ()Widowed ()Divorced

In case of Emergency notify:_____ Relationship:_____ Phone: _____

Occupation _____ () Retired () Not currently employed

Employer name and address :_____

Primary Care Physician (PCP): _____ _____
PCP Name City

Referred to this office by: () Primary Care Physician or by _____
Name City

Are you working for an employer who provides you with health insurance? ()Yes ()No
Is your spouse working for an employer who provides you with health insurance? ()Yes ()No

Is your insurance an HMO? If Yes _____
Name of HMO Group# ID#

Insurance

Primary Medical: _____Group#: _____ ID#_____
Who is insurance through?: ()Self ()Spouse ()Parent Other: _____
If not "Self": Subscriber's name: _____Birthdate_____ SSN_____
Address: () Same as patient, or _____

Secondary Medical: _____Group#: _____ ID#_____
Who is insurance through?: ()Self ()Spouse ()Parent Other: _____
If not "Self": Subscriber's name: _____Birthdate_____ SSN_____
Address: () Same as patient, or _____

Vision Insurance: _____Group#: _____ ID#_____
Who is insurance through?: ()Self ()Spouse ()Parent Other: _____
If not "Self": Subscriber's name: _____Birthdate_____ SSN_____
Address: () Same as patient, or _____

NOTICE OF PRIVACY PRACTICES

It has always been our policy to keep your medical information private. Still, Federal Law requires us to provide you with this notice. The notice describes ways in which your medical information may be used or disclosed by this office. It also describes your rights. What follows is a summary. If you need more details, ask the receptionist.

We may disclose information about you for the following purposes:

- Treatment (e.g., share information with doctors and technicians providing treatment)
- Payment (e.g., submission of claims to insurance companies for payment)
- Health care operations (e.g., health oversight activities, and health-related benefits and services)
- Appointment reminders
- Research
- As required by law (e.g., law enforcement, Medical Examiners, lawsuits and disputes)
- To avert a serious threat to health or safety

You have the right to:

- Inspect and copy your medical information (copying charges may apply)
- Request amendment of incorrect information
- Request a list of disclosures made by this office
- Request limitation on disclosure
- Request specific type of confidential communication (e.g. mail only, personal phone call only)

If you believe your privacy rights have been violated, you may file a complaint with this office or with the Secretary of the Department of Health and Human services. To file a complaint with this office, contact the office manager. All complaints must be submitted in writing. This office will not penalize you in any way for filing a complaint.

I request payment of my health insurance benefits be made on my behalf to Southland Eye Clinic, P.C.

Patient signature:_____ **Date:_____**

If patient is a minor:

Responsible Party, Print Name: _____ Relationship: _____

Responsible Party, signature: _____ Phone #: _____

Responsible Party, address: ()Same as patient, or _____

If patient has a Legal Guardian:

Legal Guardian, Print Name:_____ Relationship: _____

Legal Guardian, signature:_____ Phone #: _____

Legal Guardian, address: () Same as patient; or _____

History Form

Pt Name: _____ Birth date____/____/____ Visit date: ___/____/____

Are you allergic to?	**NO**	**YES**	
Any medicine	( )	( )	Medicine's name _____
Any eye drops	( )	( )	Drop's name _____

Have you had?	**NO**	**YES**	**Eye?**
Eye surgery	( )	( )	Rt Lt; Kind:
Eye injury	( )	( )	Rt Lt; Kind:
Other eye condition	( )	( )	Rt Lt; Kind:
Blood relative with eye condition	( )	( )	What condition? _____ ()Parent? ()Sibling? Other:

Do you have/had?	**NO**	**YES**	
Diabetes	( )	( )	For ____years?
Heart failure	( )	( )	
Low heart rate	( )	( )	
Other heart problems	( )	( )	Kind:
High blood pressure	( )	( )	
Asthma	( )	( )	
Emphysema	( )	( )	
Thyroid problems	( )	( )	
Rheumatoid arthritis	( )	( )	
Cancer	( )	( )	Kind: _____ Year diagnosed _____
AIDS/HIV	( )	( )	(Lung, colon, etc)
Stroke	( )	( )	
Other health problems	( )	( )	Kind: _____
Wear contact lenses	( )	( )	Kind: _____
Do you smoke?	( )	( )	For ____years Packs/day _____

Office use only:

() No change from last visit
() Changes; initial and date by changes
Date:_____/_____ Tech

() No change from last visit
() Changes; initial and date by changes
Date:_____/_____ Tech

() No change from last visit
() Changes; initial and date by changes
Date:_____/_____ Tech

() No change from last visit
() Changes; initial and date by changes
Date:_____/_____ Tech

() No change from last visit
() Changes; initial and date by changes
Date:_____/_____ Tech

Do you take?	**NO**	**YES**		**NO**	**YES**	
Diabetes pill	( )	( )	Heart pills	( )	( )	
Insulin	( )	( )	Water pills	( )	( )	
Prednisone	( )	( )	Thyroid pills	( )	( )	
Steroids	( )	( )	High B.P. pill	( )	( )	
Plaquenil	( )	( )	TB drugs	( )	( )	
Flomax	( )	( )	AREDS vit.	( )	( )	
Tamoxifen	( )	( )	Omega 3	( )	( )	
Accutane	( )	( )	Herb supplm	( )	( )	Kind:_____

Other meds - if you are giving us a list, please check off ( ); if not, please write in:

Do you wear?			
Sunglasses	( )	( )	(with UVA and UVB protection, in bright light; strongly suggested)
Safety glasses	( )	( )	(essential when metal working, grinding, pruning bushes and trees)

Federal government rule PQRS#226 mandates screening of all patients for tobacco use and **counseling**. Thus, we remind you that tobacco causes strokes ("the more you smoke, more you stroke"), heart attacks, emphysema and several cancers. It is also involved in a common form of blindness - macular degeneration.

Make the decision to quit, now. It will be good for you and it will be good for your family. You'll be a better role model to your children or grandchildren. And your budget will be grateful too.

There are medications to help you quit. We suggest you seek help from a family doctor who provides smoking cessation counseling. They can help a lot with advice and medications.

Please sign here: **Thank you.**

Payment Policy for Office Visits.

(For payments involving insurance companies see "Insurance and Billing")

To provide you with the best possible eye care we must continually update sophisticated diagnostic equipment and lasers. In order to be able to afford such expensive equipment we must control unnecessary administrative costs. The steps below are designed to do just that; please review them and help us to do the right thing. For your convenience we accept cash, personal checks on local banks, VISA, MasterCharge, American Express and Discovery credit cards.

We accept most major insurance policies. Our receptionists routinely attempt to determine if the services you need are covered by your insurance. However, there will be times when we cannot determine this. The responsibility for determining insurance coverage of a particular service, and who is responsible for payment, is ultimately insured's responsibility.

1. You must present your insurance card and personal identification at each visit.

2. Outstanding balance must be paid before you are seen by the doctor.

3. HMO and some managed-care companies contractually prohibit us from examining and treating you without a referral from your primary care physician. Please be sure to obtain the referral before your appointment.

4. Payment of co-pay is due at time of service. This includes the $100.00 deposit on the day of fitting of new contact lenses. Replacement contact lenses are payable in full at pick up time.

5. If you choose not to pay the co-pay on day of service, a $15.00 administrative fee for delayed payment will be added to your balance to cover expenses of re-billing. The administrative fee is not billable to your insurance company; it is your personal responsibility.

6. Returned check fee (NSF) is $25.

7. If you are unable to make it to your appointment, please notify us as soon as you become aware of it. Your appointment is a reservation of the office staff's and doctor's time and of office resources. If you let us know that you will not be coming in we can offer your time slot to patients waiting for early appointment. An administrative "No Show" fee of $25.00 (not billable to your insurance company) is charged for appointments not cancelled 24 or more hours beforehand. There is no fee if the missed appointment is due to a major snowfall or a major storm emergency.

8. A 35 percent collection fee (not billable to your insurance company) will be added to accounts turned over to our collection agency. We know that, on occasion, temporary financial problems may affect timely payment. If such a situation, contact us for assistance before the account is sent to the collection agency.

Thank you.

Administration.

Welcome to our Specialty Practice

We are a part of your Patient-Centered Medical Home (PCMH)!

Best patient care requires more and more specialists. This care needs to be coordinated.

We coordinate your care with your Primary Care Physician (PCP) through the Medical Home program (PCMH).

We:

- Provide your Primary Care Physician (PCP) with reports on our consultations with you.
- Notify your PCP of referrals needed for other specialties.
- Notify your PCP of no-shows and other actions that may place your care in jeopardy.
- Remind you when your periodic eye tests are due.
- Remind you when your annual or semi-annual visits are due.

You can help by:

- Keeping your appointments or calling us to let us know when you cannot.
- Learning about your insurance, so you know what it covers and your eligibility status.
- Telling us what medications you are taking. It is very helpful if you bring with you the list of medications you are taking.
- Following the care plan that is agreed upon-or let us know why you cannot so that we can try to help, or change the plan.
- Asking for a refill of any eye medication you need while you are at the office.
- Seeing your PCP for all preventive services.

Southland Eye Clinic, P.C.
M. K. Belamaric, M.D.
Julie A. Reno, M.D.
15055 Plaza S Drive
Taylor, MI 48180
734-287-2666

PCMH is an American College of Physicians program which assures that patients receive the best available care.

To be accepted in the program, doctors must demonstrate they use the highest standards of care and their office must pass an exhaustive inspection.

AFTER HOURS CARE

FOR **EMERGENCY** EYE CARE CALL OUR OFFICE **(734-287-2666)** AND LISTEN TO PRE-RECORDED INSTRUCTIONS.

FOR OTHER AFTER-HOURS CARE, PLEASE CONTACT YOUR PRIMARY CARE/FAMILY PHYSICIAN FOR ADVICE.

TEST RESULTS

IF YOU HAVE NOT RECEIVED A CALL OR NOTIFICATION BY MAIL WITHIN **14** DAYS AND DO NOT HAVE A FOLLOW-UP APPOINTMENT, PLEASE CALL THE OFFICE FOR YOUR RESULTS.

AVAILABLE COMMUNITY SERVICES

NEED HELP? DIAL **211** FROM ANY PHONE TO CONNECT WITH NON-PROFIT AGENCIES THAT CAN HELP WITH HUMAN, HEALTH AND SOCIAL NEEDS (I.E., UTILITIES, HOUSING, HEALTH INSURANCE, FOOD, DIAPERS, ETC.) A LISTING OF HELP RESOURCES CAN ALSO BE FOUND ON THIS WEBSITE: http://www.referweb.net/uwjc/

For practical information about eye conditions see FAQ on our website

www.southlandeyeclinic.com

PRACTICE HOURS

Monday – Friday
8am – 5pm