How to register, what to bring and what to expect at the office

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.

Please complete the "Patient Registration form" and the "History form" 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.

If you cannot make it to your appointment please let us know as soon as you become aware of it. Doing so will avoid you the "No show fees".

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 use hard or gas permeable contact lenses and you need a new prescription for glasses or contact lenses, it is best to remove your current contact lenses and wear eyeglasses for two days before coming in. This is best but it is not mandatory.

On the day of your appointment.

- Take all medications according to your regular schedule
- To see/print the map to our office click "Map" on the Home page
- Checklist of things to 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 eye drops.
    - 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 at time of service. We accept cash, local bank checks and VISA, MasterCharge, AmEx and Discovery credit cards.

What to expect at the office.

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.

After the preliminary tests, dilating drops are administered to most (but not all) patients. It may take 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.

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: _____

Email:_____ SS #: _____ () Male () Female

Preferred name (nickname): _____ Are you: () Single ()Married ()Widowed ()Divorced

Preferred contact by: () Home phone () Cell phone () Work phone () Email () USPS mail

Occupation _____ () Retired () Not currently employed

Employer name and address :_____

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

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

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

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 _____

Please see back

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. 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.

If you do not want your medical information released to a specific person or entity please enter name of person or entity here: _____Sign and date: _____

Name of person or entity

If you need additional details about the Notice of Privacy Practice - ask the receptionist.

I acknowledge receipt of the above Notice of Privacy Practice. Also, I request payment of my health insurance benefits be made on my behalf to Southland Eye Clinic, P.C.

Patient signature:_____ Date:_____

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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 _____

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. To be able to pay for 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. We do not have sufficient insurance information, particularly on new patients, to determine patient's coverage. Furthermore, insurance companies change their benefits and do not inform us about it. It is important for you to find out if a planned service is covered by their policy.

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

2. Co-pay 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. The contact lenses $100.00 deposit is payable on the day of fitting of new contact lenses. Replacement contact lenses are payable in full at pick up time.

5. Returned check fee (NSF) is $25. It is an administrative fee not covered by insurance.

6. The "No Show" fee is $25. It is an administrative fee not covered by insurance.

   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 try to offer your time slot to patients waiting for early appointment. An administrative "No Show" fee of $25.00 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.

7. The collection fee is 35 percent of the balance. It is an administrative fee not covered by insurance. It will be added to accounts turned over to the collection agency. We know that, on occasion, temporary financial problems may affect timely payment. If you are in such a situation, contact us for assistance before the account is sent to the collection agency.

Thank you.

Administration.

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.**