PATIENT INFORMATION FOR THE GLAUCOMA CENTER OF MICHIGAN DATE______________

MR. MRS. MS. MISS____
(LAST) (FIRST) (MIDDLE)

ADDRESS____

CITY, STATE, ZIP CODE____

HOME PHONE (   )_____________________________CELL OR 2ND # (   )_________________________

BIRTHDATE_______________________________________SOC. SEC. #_____________________________________

EMAIL ADDRESS____

PATIENT EMPLOYER____________________________________PHONE___________________________________

SPOUSE NAME_____________________________________BIRTHDATE__________________________________

SPOUSE EMPLOYER_____________________________________PHONE (   )____________________________

WHO REFERRED YOU TO OUR OFFICE? DR. MR. MS.____

IF DR. REFERRED – ADDRESS____

____PHONE (   )____________________________

**************************INSURANCE INFORMATION**************************

PRIMARY INSURANCE____

SUBSCRIBER NAME_____________________________________BIRTHDATE________________________________

SECONDARY INSURANCE____

SUBSCRIBER NAME_____________________________________BIRTHDATE________________________________

AUTO RELATED __________YES __________NO WORK RELATED __________YES __________NO

I AUTHORIZE THE FOLLOWING TO BE MY EMERGENCY CONTACT PERSON(S) AND/OR DISCUSS MY CARE IN MY ABSENCE:

NAME____PHONE (   )______________________________

NAME____PHONE (   )______________________________

I HEREBY AUTHORIZE THE RELEASE OF THE NECESSARY MEDICAL INFORMATION TO PROCESS CLAIMS AND DIRECT PAYMENT OF BENEFITS TO THE PHYSICIAN RENDERING SERVICES. I AM RESPONSIBLE TO PAY NON-COVERED SERVICES, CO-PAYS, AND DEDUCTIBLES. IF MY INSURANCE IS AN HMO AND MY REFERRAL IS NOT VALID I WILL BE RESPONSIBLE FOR ALL CHARGES.

PATIENT SIGNATURE (PARENT OR GUARDIAN IF MINOR)____

MEDICAL HISTORY QUESTIONNAIRE
DATE__________________

NAME____DATE OF BIRTH________________

REFERRING EYE DOCTOR:______________________________PHONE:______________
ADDRESS:____

____
City State Zip

MEDICAL DOCTOR:___________________________________PHONE:______________
ADDRESS:____

____
City State Zip

ARE YOU BEING TREATED FOR GLAUCOMA? ____YES ____NO IF YES HOW LONG? ______________

WHAT MEDICATIONS ARE YOU ON FOR YOUR EYES?

____
____
____
____

DO YOU TAKE DIAMOX OR NEPTAZANE FOR YOUR EYE PRESSURE? ____YES ____NO (Please circle which one)

HAVE YOU HAD ANY SURGERY ON YOUR EYES?
____YES ____NO WHAT?__________________

CATARACT SURGERY? ____YES____NO WHEN?_______

GLAUCOMA SURGERY?____YES____NO WHEN?_______

HAVE YOU HAD ANY LASER TREATMENTS ON YOUR EYES?____YES____NO WHEN?________________

IS THERE ANY FAMILY HISTORY OF GLAUCOMA?
____YES____NO IF YES WHO?__________________

PLEASE LIST ALL OTHER MEDICATIONS (Including Vitamins):

____
____
____
____
____

PLEASE LIST **ALL** OTHER SURGERIES YOU HAVE HAD:
(NOT EYE SURGERY)

____
____
____
____
____

ARE YOU ALLERGIC TO ANY MEDICATIONS?____YES____NO
WHICH DRUGS?______________________________

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

DIABETES
____YES ____NO HOW LONG?______________

HIGH BLOOD PRESSURE
____YES ____NO HOW LONG?______________

KIDNEY STONES
____YES ____NO HOW LONG?______________

ANGINA
____YES ____NO WHEN?______________

HEART ATTACK
____YES ____NO WHEN?______________

STROKE
____YES ____NO WHEN?______________

HAVE YOU EVER BEEN IN SHOCK?
____YES ____NO WHEN?______________

HAVE YOU EVER HAD A BLOOD TRANSFUSION?
____YES ____NO WHEN?______________

HAVE YOU EVER USED STERIOD DRUGS?
____YES ____NO (CORTISONE/PREDNISONE)

ASTHMA / EMPHYSEMA
____YES ____NO HOW LONG?______________

MIGRAINE HEADACHES
____YES ____NO HOW LONG?______________

HIV
____YES ____NO HOW LONG?______________

TB ____YES ____NO HOW LONG?______________

HEPATITIS ____YES ____NO HOW LONG?______________

DO YOU SMOKE?____YES ____NO IF YES
Please Circle - Occasional / Regularly ______pack(s) per day

DO YOU DRINK ALCOHOL?____YES ____NO IF YES
Please Circle - Occasional / Regularly ______drink(s) per day

ARE YOU BEING TREATED FOR ANY OTHER CONDITION NOW?____YES ____NO IF YES – WHAT?______________

PLEASE SEE THE OTHER SIDE TO REVIEW OTHER CONDITIONS

Medical History Questionnaire reviewed by Physician________________________________
PHYSICIAN SIGNATURE

PATIENT NAME: ______________________________ DATE: ______________

REVIEW OF SYSTEMS: If you are currently having any problems in the following areas, circle and explain (if necessary).

CONSTITUTIONAL SYMPTOMS: (e.g., fever, weight loss) Explain:	None_______
SKIN: Itching, rash, infection, ulcer, tumors (growths), other Explain:	None_______
LYMPH NODES: Swelling, tenderness, other Explain:	None_______
BONES, JOINTS, MUSCLES: Muscle pain/cramps, joint pain/swelling, other Explain:	None_______
ENDOCRINE: Fatigue, confusion fainting, nervousness, hot/cold intolerance, hair loss, excessive hair growth, other Explain:	None_______
ALLERGY/IMMUNOLOGY: Recurrent infections, hay fever, hives, food allergy, drug sensitivity/allergy, other Explain:	None_______
HEAD: Headaches, dizziness, vertigo, other Explain:	None_______
EARS: Hearing loss, ringing, infection, other Explain:	None_______
NOSE: Bleeding, loss of smell, congestion, other Explain:	None_______
THROAT: Dry mouth, loss of taste, difficulty swallowing, hoarseness, other Explain:	None_______
NECK: Pain, swelling, stiffness, other Explain:	None_______
BREASTS: Tenderness, swelling, lumps, discharge, other Explain:	None_______
BLOOD: Fever/chills, easily bruised, prolonged bleeding, skin hemorrhages, significant blood loss, other Explain:	None_______
RESPIRATORY: Wheezing cough (productive/ blood), difficulty breathing, other Explain:	None_______
CARDIOVASCULAR (HEART/BLOOD VESSELS): Chest pain, cold hands/feet, swelling of extremities, shortness of breath, exercise intolerance, other Explain:	None_______
GASTROINTESTINAL (stomach/intestines): Nausea, vomiting, change in bowel habits, Constipation, diarrhea, bleeding, pain/cramps, other Explain:	None_______
GENITOURINARY (genitals/kidneys/bladder): Frequency, burning, hesitancy, pain or bleeding on urination, stones, infections, incontinence, impotence, other Explain:	None_______
NERVOUS SYSTEM: Weakness in arms/legs, numbness/tingling, loss of consciousness, falls, difficulty walking, seizures, tremors, neuralgia, other Explain:	None_______
PSYCHIATRIC: Disorientation, mood swings, anxiety, depression, hallucinations, other Explain:	None_______

SIGNATURE OF PATIENT ______________________________

OVER

GLAUCOMA CENTER OF MICHIGAN
INSURANCE AND FINANCIAL INFORMATION

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our financial policy which we require that you read and sign prior to any treatment.

REGARDING INSURANCE

We participate with most commercial insurance companies. If you do not completely understand your insurance policy or have questions regarding covered services, we encourage you to call your insurance company prior to your visit. The services rendered will be billed under your **medical – NOT vision benefits.** Exceptions are Co/op Optical, and SVS-Ford Programs. You must bring with you all proper insurance information necessary for us to bill your insurance company.

There are many types of commercial insurance companies. Please be advised of the HMO's, which require a written referral from your primary care physician **not the physician who referred you to our office. You must have your referral in hand at the time of your visit or you will be asked to reschedule your appointment until the referral is obtained.** Providing we participate, most PPO's require a co-payment at the time of your visit. Payment is due at the time of service. Please contact your insurance company to see if we are a participating physician.

Please be aware some and perhaps all of the services provided may be **"NON-COVERED"** services. **This also applies to HMO policies even if authorized by your Primary Care Physician.** These services may also be applied to your yearly deductible or require a co-payment. **Most insurance companies DO NOT pay for services at 100%.** Any disputes regarding payment is up to you to resolve with the insurance company.

Please help us serve you better by keeping scheduled appointments or give us a 24 hour notice if you need to cancel.

FAILING TO COMPLY WITH THESE SUGGESTIONS COULD RESULT IN YOU, THE PATIENT, BEING RESPONSIBLE FOR PAYMENT IN FULL.

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Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns. We would be more than happy to provide you with assistance. You can contact our office Monday thru Friday 9:00 a.m. till 4:30 p.m., at (248) 356-1321.

I have read the Financial Policy (above). I understand and agree to the Financial Policy:

____ Date:____________________

Signature - Patient or Responsible Party

____ Date:____________________

Signature - Co-Responsible Party

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WE ACCEPT CASH, CHECK, AND VISA / MASTER CARD

NOTICE OF PRIVACY PRACTICES

Effective date: April 14, 2003

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.

IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT THE GLAUCOMA CENTER OF MICHIGAN.

Your medical information is personal. We are committed to protecting your medical information. We create a record of the care and services you receive at this office. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated by this office whether made by your personal physician or one of the office's employees.

This Notice will tell you about the ways in which we may use and disclose your medical information. This Notice will also describe your rights and certain obligations we have regarding the use and disclosure of your medical information.

This office is required by law to:

(1) make sure that medical information that identifies you is kept private;
(2) give you this Notice of our legal duties and privacy practices with respect to medical information about you; and
(3) follow the terms of the Notice that is currently in effect.

How this Office May Use and Disclose Your Medical Information

The following describes the different ways that your medical information may be used or disclosed by this office. For clarification we have included some examples. Not every possible use or disclosure is specifically mentioned. However, all of the ways we are permitted to use and disclose your medical information will fit within one of these general categories:

For Treatment. We will use medical information about you to provide you with medical treatment and services. We may disclose medical information about you to doctors, nurses, technicians and other office personnel who are involved in providing you medical treatment.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about treatment you received here so your health plan will pay us or reimburse you for the treatment. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

For Health Care Operations. We may use and disclose medical information about you for office operations. These uses and disclosures are necessary to run our office and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many of our patients to decide what additional services the office should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, and other office personnel for review and learning purposes. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning the identity of the specific patient.

Appointment Reminders. We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at this office.

Treatment Alternatives. We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Benefits and Services. We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

Research. Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another for the same condition.

As Required By Law. We will disclose medical information about you when required to do so by federal, state or local law. For example, disclosure may be required by Workers' Compensation statutes and various public health statutes in connection with required reporting of certain disease, child abuse and neglect, domestic violence, adverse drug reactions, etc.

To Avert a Serious Threat to Health or Safety. We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Health Oversight Activities. We may disclose medical information to a governmental or other oversight agency for activities authorized by law. For example, disclosures of your medical information may be made in connection with audits, investigations, inspections, and licensure renewals, etc.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may use your medical information to defend the office or to respond to a court order.

Law Enforcement. We may release medical information about you if required by law when asked to do so by a law enforcement official.

Coroners and Medical Examiners. We may release medical information to a coroner or medical examiner to identify a deceased person or determine the cause of death.

Your Rights Regarding Your Medical Information:
You have the following rights regarding the medical information this office maintains about you:

Right to Inspect and Copy. You have the right to inspect and copy your medical information with the exception of any psychotherapy notes.

To Inspect and copy your medical information, you must submit your request in writing to the Glaucoma Center of Michigan. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed. For information regarding such a review contact the Privacy Officer at the Glaucoma Center of Michigan.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by this office.

To request an amendment, your request must be made in writing and submitted to the Glaucoma Center of Michigan. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

(a) Was not created by us;
(b) Is not part of the medical information kept by this office;
(c) Is not part of the information which you would be permitted to inspect and copy; or
(d) Is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures this office has made of your medical information.

To request this accounting of disclosures, you must submit your request in writing to the Glaucoma Center of Michigan. Your request must state a time period which may not be longer than six years and may not include dates before February 26, 2003.

Right to Request Restrictions. You have the right to request a restriction or limitation on the use of disclosure we make of your medical information.

We are not required to agree to your request for a restriction. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must make you request in writing to the Glaucoma Center of Michigan.

Right to Request Confidential Communications. You have the right to request that we communicate with you only in a certain manner. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to the Glaucoma Center of Michigan. We will accommodate all reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.

You may obtain a copy of this Notice at our website, www.glaucomacenter.com

To obtain a paper copy of this Notice, contact the Glaucoma Center of Michigan.

Revisions to This Notice

We reserve the right to revise this Notice. Any revised Notice will be effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of any revised Notice in this office. Any revised Notice will contain on the first page, the effective date. In addition, each time you visit the office we will offer you a copy of the current Notice in effect.

Complaints

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 Pat Rizzo, Privacy Officer at (248) 356-0098. All complaints must be submitted in writing.

THIS OFFICE WILL NOT PENALIZE YOU IN ANY WAY FOR FILING A COMPLAINT.

Other Uses of Medical Information
Other uses and disclosures of your medical information not covered by this Notice of Privacy Practices will be made only with your written authorization. If you provide us such an authorization in writing to use or disclose medical information about you, you may revoke that authorization, in writing at any time. If you revoke your authorization, we will no longer use or disclose medical information about you for the reasons covered by your written authorization.

GLAUCOMA CENTER OF MICHIGAN

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below I acknowledge that I have received a copy of this office's Notice of Privacy Practices Form.

____

Patient Signature **Date**

OR

____

Patient Name Printed **Signature of Guardian or Power of Attorney**

____

Date

THE PATIENT REFUSED TO PROVIDE A SIGNATURE WHEN REQUESTED.

____

Patient Name

____

Date