Signature on File, Assignment of Benefits, Financial Agreement

_____ _____

Beneficiary Name *(print)* Identification Number

1. **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to Ogemaw Eye Institute, for services furnished me by Ogemaw Eye Institute. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Ogemaw Eye Institute accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and noncovered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

2. **MEDIGAP:** I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Ogemaw Eye Institute, if possible or otherwise to me.

3. **RELEASE OF INFORMATION:** Ogemaw Eye Institute may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to Ogemaw Eye Institute for reimbursement for services rendered, and (2) any health care provider for continued patient care. Ogemaw Eye Institute may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation. A copy of this authorization may be used in place of the original.

4. **OTHER INSURANCE:** I understand that Ogemaw Eye Institute maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office and that Ogemaw Eye Institute has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Ogemaw Eye Institute if I belong to a plan that does not appear on the above-mentioned list.

5. **NON-COVERED SERVICES:** I understand that Ogemaw Eye Institute contracts with health care service plans (i.e., HMOs, PPOs) relate only to items and services which are covered by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient and treatment, or tests not authorized by the health care service plan. The undersigned agrees to cooperate with Ogemaw Eye Institute to obtain necessary health care service plan authorizations.

6. **FINANCIAL AGREEMENT:** I agree that in return for the services provided to the patient by Ogemaw Eye Institute, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Ogemaw Eye Institute for payment. If my account is sent to a collection service or attorney, I agree to pay all reasonable fees associated with collecting my debt. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to Ogemaw Eye Institute. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Ogemaw Eye Institute. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

X_____ _____

Beneficiary Signature or Authorized Party **Date**

Name: _____ **Date of Birth:** _____ **Date:** _____
Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Cell #: _____ **Home #:** _____ Text message reminders **YES / NO**
SS#:_____ **Gender:** _____ **Email:** _____
Preferred Pronoun: _____ **Preferred Name:** _____

Please Circle Answers

Language: English / Spanish / Polish / Japanese / Sign Language / Other
Ethnicity: Hispanic or Latino / Not Hispanic or Latino / Unknown or Not Reported
Marital Status: Married / Single / Divorced / Widowed / Legally Separated

Primary Care Physician: _____ **Location:** _____

Emergency Contact:
Name: _____ Phone #: _____ Relationship: _____

Insurance:
Primary: _____ Member ID: _____
Secondary: _____ Member ID: _____
Vision: _____ Member ID: _____

Eye History (circle): Cataract Surgery – Glaucoma – Neurological problems (Nerve Palsy/ Bell's Palsy) – Retinal problems – Floaters – Dry Eye – Corneal injuries/surgeries – Amblyopia – Strabismus – Eye surgeries (cataract, glaucoma, lid, LASIK, RK) and dates:
Eye Drops/Medications: _____

Medical History (circle): Arthritis /Other Arthritis_____ - Cancer (type) _____
Heart Disease – High Blood Pressure – High Cholesterol – Diabetes – HIV / Hepatitis A/B/C – Sjogren's Disease – Stroke – Thyroid Disease – Grave's Disease
Other Medical History: _____

Medications: Including supplements: _____

_____

_____

Or allow access to pharmacy for medication **YES / NO**

Pharmacy Name: _____ Location: _____

Allergies/Reactions: _____

OGEMAW EYE INSTITUTE

Family History: Unknown/Adopted – Blindness – Color Blindness – Cancer (type) _____
Corneal Disease – Cross Eyed (strabismus) – Lazy Eye (amblyopia) – Macular Degeneration – Retinal Disease – Glaucoma - Other: _____

Surgical History: _____

_____

Social History: Smoking/Tobacco/Vaping: Yes / No / Former- If yes, how many packs? _____

Alcohol: Yes / No If yes circle how often? Occasional / 1-2 daily / 3-4 daily / Other: _____

Caffeine: Yes / No

Fall Risk Assessment: No falls in the current/last year / 1 or more falls in the current/last year

Allergy / Immunology:
- ☐ Autoimmune Disease
- ☐ Seasonal Allergies
- ☐ Other: _____

Cardiovascular: Heart
- ☐ Chest Discomfort
- ☐ Irregular Heartbeat
- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Other: _____

Genitourinary:
- ☐ Bladder Trouble
- ☐ Kidney Failure
- ☐ Kidney Problems

Other: _____

Hematology / Oncology:
- ☐ Bleeding
- ☐ Easy Bruising
- ☐ Other: _____

Musculoskeletal: Bones/Muscle
- ☐ Back Pain
- ☐ Joint Swelling
- ☐ Muscle Weakness
- ☐ Arthritis
- ☐ Other: _____

Psychiatric: Mental Health
- ☐ Depression
- ☐ Anxiety Disorder
- ☐ Bipolar
- ☐ Schizophrenic
- ☐ ADHD
- ☐ Other: _____

HENT: Ears, Nose, Throat
- ☐ Hearing Loss
- ☐ Sinus Problems
- ☐ Sore Throat
- ☐ Other: _____

Neurological: Nervous System
- ☐ Poor Balance
- ☐ Dizziness
- ☐ Headaches
- ☐ Memory Loss
- ☐ Seizures / Convulsions
- ☐ Other: _____

Integumentary: Skin
- ☐ Rash
- ☐ Severe Itching
- ☐ Other: _____

Patient's Name: _____

Ogemaw Eye Institute (hereafter referred to as OEI) is committed to protecting the privacy of its patients' personal health information (PHI).

Uses and Disclosure:
OEI may use or disclose your PHI for purposes of treatment, payment, or practice operations only with your written consent. For example, OEI may contact another physician to coordinate your care, submit a claim to an insurer, or look at your file to perform internal quality monitoring. OEI must obtain your written authorization for any other use or disclosure. You may revoke your consent or authorization at any time in writing. This will not apply to information used or disclosed while the consent or authorization was in effect.

OEI will provide access to your information, without your consent or authorization, when required to do so by law or regulation. Access may be granted to public health and law enforcement authorities, health care oversight agencies, government benefits programs, employers (in case of work-related illness or injury), courts and administrative tribunals.

Your Individual Rights:
In most cases you have the right to review or to purchase copies of you PHI. You have the right to receive an accounting of the instances, if any, in which your PHI was disclosed for purposes other than treatment, payment, or health care operations, pursuant to a signed authorization from you, or certain other disclosures OEI is permitted to make without your authorization. You have the right to request that OEI place additional restriction on our use or disclosure of your PHI, but OEI is not required to honor such a request. OEI will be bound by such restrictions only if we agree to do so in writing signed by our Privacy Officer.

You have the right to request OEI amend your PHI. Any such request must be in writing and contain a detailed explanation for the requested amendment. Under certain circumstance, OEI may dent your request but will provide you a written explanation of the denial. You have the right to send us a statement of disagreement to which we may prepare a rebuttal, a copy of which will be provided to you at no cost. Please contact our Privacy Officer with any further questions about amending your medical records.

Complaints:
If you believe OEI has violated your privacy rights, you may file a complaint with OEI by notifying our Privacy Officer in writing or with the Secretary of the U.S. Department of Health and Human Services as permitted by law. OEI will not retaliate in any way if you chose to file a complaint.

Authorization:
I authorize OEI to leave lab results, test results and/or treatment plans with the individual listed below and/or on my answering machine in the event they are unable to speak with either myself or that person. Financial information related to my care may also be discussed with the individual listed below.

______________________	______________	__________	______________
Print Authorized Individual's Name	Relationship to Patient	Birth Date	Phone Number

_________ I request that OEI not leave messages on my answering machine

_ _

X______________________	______________	__________	__________
Patient or Personal Rep Signature	Print Name	Birth Date	Date

If Personal Representative's signature appears above, please describe relationship to patient: ____________________________