OGEMAW EYE INSTITUTE

It is important that you read and acknowledge out **Policies and Procedures** in full.

Policies and Procedures

Payment in full for services and products are due at the time services are performed or products are ordered. As the patient/guarantor, **you are financially responsible for any fees and costs associated with any services or products you receive from our office.** This includes any medical service or visit, routine examination, testing, contact lens services and any other screening ordered by the doctor or staff.

Co-payments and refraction fees will be collected at the time of service. There will be a $20 fee for returned checks.

As the patient/guarantor, **it is your responsibility to know your insurance benefits** and to **provide our office with accurate and current insurance information**. If your specific insurance plan requires a referral, it is your responsibility to obtain the referral from your primary care physician. If you arrive for an appointment without a referral on file, you have the option to reschedule or to pay in full for all services rendered.

If you are a Medicare patient with a secondary insurance to your Medicare plan, it is your responsibility to provide both insurance identification cards. If the office does not have the proper information for a secondary insurance, the secondary insurance will not be billed.

We will bill your insurance as applicable, however, you are ultimately liable for any fees and costs not covered or paid by your insurance. **Questions about non-payment should be directed to your insurance company.**

Due to ongoing **insurance policy changes,** it is no longer an easy task to monitor each individual policy. Although we make every effort to stay informed of policy changes, it is not always possible. **Ultimately, it is your responsibility** to understand your individual coverage. Therefore, we strongly encourage you to check with your insurance company prior to any office or hospital procedure.

If you are unable to keep your scheduled appointment, we ask that you give adequate notice (48 hours when possible, or prior to appointment time on the same day in an emergency situation) so that we may open your reserved time for another patient. There is a $40 charge "No show fee" for missed appointments if they are not cancelled. If you miss two appointments without prior cancellation, you will be required to pay the $40 fee prior to scheduling further appointments.

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Fee Schedule	
Procedure Name:	Price:
Refraction	$50
Contact Lens Exam	$30-$100
Testing:	
OCT MAC/RNFL	$50-$125
Visual Field	$105-$195
Fundus Photos	$70-$120
Gonioscopy	$60-$110
IOL Master	$190
LASERS:	
SLT	$600
Peripheral Iridectomy	$1300
Laser Iridotomy	$915
YAG	$1000
Focal	$1225
PRP	$810
Retinopexy-photocoagulation	$1254

Medical vs. Vision Insurance

Medical insurance/exams: when a medical condition exists such as (but not limited to) cataracts, glaucoma, dry eyes, diabetes, high blood pressure, or any other condition related to the health of the eye, it will be necessary for the doctor to perform a full and comprehensive ocular health exam. This exam may include further testing beyond the scope of a routine eye exam. **With a medical diagnosis, your exam and testing will be billed to your medical insurance, and you will be responsible for any co-pays, deductibles, and/or co-insurance as dictated by your specific plan. If you are diabetic, your exam will be billed to your medical insurance without exception.**

Vision insurance/exam: **vision coverage for a routine examination is designed to provide a screening evaluation of the eye to determine a prescription for glasses only**. This evaluation is not a comprehensive ocular health examination and excludes any testing to diagnose, evaluate and follow medical issues. This evaluation also does not include a contact lens evaluation, or any fees associated with contact lenses.

***We CAN NOT bill medical and vision insurance for the same visit.**

Refractions: a refraction is the portion of the examination process where the doctor or technician places various lenses in front of your eyes to determine spectacle prescription. **This service is considered to be a non-covered service by Medicare and most secondary insurance plans**. **The fee for this service is $50 and is collected when a refraction is performed whether or not you have had a change in your prescription**. A spectacle prescription is valid for two years from the date of the refraction; you will need to have refractions as part of your exam in order to maintain a current prescription.

Contact Lenses: **contact lens services are considered to be elective and therefore not covered by medical insurance, and often not covered by vision insurance**. A contact lens prescription is valid for one year from the date of issue. In order to maintain a current contact lens prescription, you must have annual contact lens evaluations with your doctor. **Payments for a contact lens evaluation, whether performed independently or as part or your comprehensive eye exam, is expected at the time of service.** A separate contact lens agreement will be signed prior to a contact lens fitting or refitting.

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Patient Responsibility:

I understand and agree that I am financially responsible for all charges for any and all services rendered. This includes any medical service, routine examination, refraction, testing, contact lens services and any other screening order by the doctor.

I understand that while my insurance may confirm my benefits, confirmation of benefits is not guarantee of payment and that I am responsible for any unpaid balance.

I understand and agree that it is my responsibility to know if my insurance has any deductible, co-payment, co-insurance, out-of-network, usual and customary limit, prior authorization requirements or any other type of benefit limitation for the services I receive and I agree to make payment in full.

I understand and agree that it is my responsibility to know if my insurance requires a referral from my primary care physician and that it is up to me to obtain the referral. I understand that without this referral my insurance will not pay for any services and that I will be financially responsible for all services rendered.

I agree to inform the office of any changes in my insurance coverage. If my insurance has changed or is terminated at the time of service, I agree that I am financially responsible for the balance in full.

If I am a Medicare patient, I understand that I need to provide the office both my Medicare ID and my secondary ID card. If the office does not have the proper information for secondary insurance, the secondary will not be billed. It will be my responsibility to pay the balance and then file a claim with the secondary for reimbursement.

By signing this form, I consent to the use and disclosure of protected health information about me for treatment, payment, and health care operations, and/or as required by law. I have the right to revoke this Consent, in writing, signed by me. However, such revocation shall not affect any disclosures already made in compliance with my prior Consent. Ogemaw Eye Institute provides this form to comply with Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Print Patient Name (and Guardian Name if applicable): _____

Patient or Guardian Signature: _____

Date: _____

Please keep in mind that our office does not make the rules. They are determined by your specific medical insurance or vision plan.

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

Please Circle Answers

Race: White / African American / Hispanic / Indian / Multiracial / Native American / Other
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 - 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: _____

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

OGEMAW EYE INSTITUTE

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 he 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

_ _

______________________	______________________	______________	______________
Patient or Personal Rep Signature	Print Name	Birth Date	Date

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