

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



OGEMAW EYE INSTITUTE

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

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 _____	Print Name	Birth Date	Date

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



Patient Consent to Use Unencrypted E-mail or Text

It is very important that you are aware that computer e-mail, texts, and e-fax communication, can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication.

E-mails, texts, and e-faxes, in particular, are vulnerable to such unauthorized access due to the fact that servers or communication companies may have unlimited and direct access to all e-mails, texts and e-faxes that go through them.

It is always a possibility that e-faxes, texts, and e-mail can be sent erroneously to the wrong address and computers. Unencrypted e-mail or texts provide as much privacy as a postcard. You should not communicate any information to your health care provider that you would not want to be included on a postcard that is sent through the Post Office.

E-mail messages on your computer, your laptop, iPad, phone or other devices have inherent privacy risks – especially when your e-mail access is provided through your employer or when access to your e-mail messages is not password protected.

Please, note that e-mails, faxes, and texts are all part of your clinical records. Also, be aware that phone messages are transcribed and sent to “Ogemaw Eye Institute” via unencrypted e-mails.

Please notify Ogemaw Eye Institute if you decide to avoid or limit, in any way, the use of e-mail, texts, cell phone calls, phone messages, or e-faxes. If you communicate confidential or private information via unencrypted e-mail, texts or e-fax or via phone messages, it will be assumed that you have evaluated the risks and made an informed decision. Ogemaw Eye Institute will view it as your agreement to take the risk that such communication may be intercepted, and your desire to communicate on such matters will be honored.

Emergencies: Please do not use texts, e-mail, voice mail, or faxes for emergencies.

Patient's Name: _____

Date: _____

Cell Phone #: _____

Email Address: _____

Patient Signature: _____