traverse city eye
a clear vision of care.

PATIENT REGISTRATION INFORMATION

PATIENT INFORMATION

First, Middle Initial, Last	Social Security #	Gender Preference ☐ M ☐ F ☐ Other_____	Date of Birth

Mailing Address	City	State	ZIP

Email Address	Primary Phone	Secondary Phone

Preferred Contact Method ☐ Text ☐ Primary Phone ☐ Secondary Phone	Language Preference ☐ English ☐ Spanish ☐ Other_____	Interpreter Needed? ☐ Yes ☐ No

Race/Ethnicity – Select all that apply. ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian ☐ Other Pacific Islander ☐ White/Caucasian ☐ Other **Are you Hispanic?** ☐ Yes ☐ No	Type of Housing ☐ Own ☐ Other Shelter ☐ Rent ☐ Public Housing ☐ Homeless ☐ Staying with Friends/Family

Emergency Contact Name	Relationship to Patient	Emergency Contact Phone

INSURANCE & GUARANTOR INFORMATION

Primary Insurance	Policy #	Group #

Subscriber Name	Relationship to Patient

Secondary Insurance (if applicable)	Policy #	Group #

Subscriber Name	Relationship to Patient

Guarantor/Name of Person Responsible for Payment (if different from Subscriber)

Address	City	State	ZIP

Phone	Relationship to Patient

Preferred Pharmacy	Preferred Lab

Patient/Guarantor Signature	Date

Patient Health History

Name: _____ **Date of Birth:** _____

Height: ____ Weight: _____ Primary Care Physician: _____

CONDITIONS:	**Circle any and all conditions that apply to you or check none.**	**NONE**
GENERAL:	Fever, Heat stroke, Weight loss, Weight gain, Fatigue, Insomnia, Headaches	
EARS, NOSE, THROAT:	Hard of hearing, Ear ache, Cough, Dry mouth, Sinus/allergy, Hoarseness, Vertigo	
CARDIOVASCULAR:	High B/P, Heart attack, Chest pain, Congestive heart failure, Racing pulse, High cholesterol, Irregular heartbeat, Palpitations, Pace maker	
RESPIRATORY:	Congestion, Wheezing, Short of breath, Asthma, COPD, Emphysema, TB exposure	
GASTROINTESTINAL:	Stomach upset, Diarrhea, Constipation, Hernia, Ulcers, Nausea, GERD,	
GENITOURINARY:	Painful/ frequent urination, Impotence, Yellow jaundice, Kidney stones, Blood in urine	
FEMALES:	Are you pregnant? Are you nursing?	
MUSCULOSKELETAL:	Joint pain, Stiffness, Swelling, Cramps, Fibromyalgia, Rheumatoid Arthritis, Lupus, Other type arthritis, Osteoporosis	
DERMATOLOGIC:	Pimples, Acne, Warts, Growths, Rash, Rosacea, Melanoma	
NEUROLOGICAL:	Numbness, Headache, Seizures, Paralysis, Stroke, Dementia, Memory loss, Alzheimer's, Parkinson's	
PSYCHIATRIC:	Anxiety, Depression,	
ENDOCRINE:	Diabetes, Hypothyroid, Hyperthyroid, Hormone, Increased thirst , Graves Disease, Thyroid Eye Disease	
HEMATOLOGY:	Bleeding, Anemia, Blood clots, Problems related to blood transfusions,	
ALLERGIC/IMMUNOLOGIC:	Sinus, Sneezing, Swelling, Redness, Itching, Hives, Lupus, HIV, Herpes Simplex Virus, Sjogren's Syndrome, Rheumatoid arthritis,	
CANCER:	Breast, Prostate, Lung, Skin, Colon , Other _____	
EYES:	Cataract, Glaucoma, Detached retina, Blindness, Lazy eye, Eye injury/trauma, Corneal problems, Macular degeneration	

List all Eye Surgeries & Laser Eye Surgeries:

_____

_____

List all OTHER surgeries you have had:

_____

_____

FAMILY HISTORY: Has any member of your immediate family (blood relatives) have/had these diseases?

Disease/Condition			**Family Member**	**Disease/Condition**			**Family Member**
Lazy Eye	yes	no	Mother Father Sibling Grandparent	Heart Disease	yes	no	Mother Father Sibling Grandparent
Macular Degeneration	yes	no	Mother Father Sibling Grandparent	Hypertension	yes	no	Mother Father Sibling Grandparent
Blindness	yes	no	Mother Father Sibling Grandparent	Stroke	yes	no	Mother Father Sibling Grandparent
Retinal Disorders	yes	no	Mother Father Sibling Grandparent	Thyroid Disease	yes	no	Mother Father Sibling Grandparent
Cataracts	yes	no	Mother Father Sibling Grandparent	Arthritis	yes	no	Mother Father Sibling Grandparent
Glaucoma	yes	no	Mother Father Sibling Grandparent	Cancer	yes	no	Mother Father Sibling Grandparent
Diabetes	yes	no	Mother Father Sibling Grandparent	Type of Cancer: _____			Mother Father Sibling Grandparent

Patient Health History

Patient Name:____**Date of Birth:**____________________

<u>FAMILY MEDICAL HISTORY CONTINUED:</u>

Is mother deceased? Y / N If yes- cause of death?_______________________ Age at death?_______

Is father deceased? Y / N If yes- cause of death?_______________________ Age at death?_______

<u>SOCIAL HISTORY</u>:

(<u>Circle:)</u> Student Homemaker Employed Retired **<u>(Circle:)</u>** Single Married Separated Divorced Widowed

Do you use Tobacco? Yes / No Cigarettes / Smokeless _____ # Packs/Times a Day ______# of Years

Do you use Alcohol? Yes / No Rarely Daily Weekly 1-2 drinks 2-4 drinks Other ____________

Substance Abuse? Yes / No Rarely Daily Weekly ______________________________________

<u>LIST ANY DRUG ALLERGIES:</u> ____

<u>List all Prescriptions and Over the Counter medications you are taking: (Including Eye Drops)</u>

If you have a list, please give to receptionist to copy in lieu of filling out form: **REVIEWED:**

Medication Name	Dosage	Taken how often ? PRN= when needed	Route	Reason for taking	Currently Taking Yes	No	Staff Initials	Date
		____ Times a day ____ or PRN	__ Oral __ Topical __ Injection					
		____ Times a day ____ or PRN	__ Oral __ Topical __ Injection					
		____ Times a day ____ or PRN	__ Oral __ Topical __ Injection					
		____ Times a day ____ or PRN	__ Oral __ Topical __ Injection					
		____ Times a day ____ or PRN	__ Oral __ Topical __ Injection					
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		____ Times a day ____ or PRN	__ Oral __ Topical __ Injection					
		____ Times a day ____ or PRN	__ Oral __ Topical __ Injection					
		____ Times a day ____ or PRN	__ Oral __ Topical __ Injection					
		____ Times a day ____ or PRN	__ Oral __ Topical __ Injection					
		____ Times a day ____ or PRN	__ Oral __ Topical __ Injection					

<u>Physician Signature:</u> ____ **<u>Date:</u>** _________________

PATIENT FINANCIAL POLICY

Thank you for choosing Traverse City Eye Consultants, P.C. as your eye and vision care provider. We are committed to building a successful physician-patient relationship with you and your family. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. Please ask if you have any questions about our fees, our policies, or your responsibilities. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance information, etc).

Co-pays
The patient is expected to present an insurance card at each visit. All co-payments and past due balances are due at time of check-in unless previous arrangements have been made with a billing coordinator. We accept cash, check or credit cards. No post-dated checks will be accepted.

Insurance Claims
Insurance is a contract between you and your insurance company. In most cases, we are NOT a party of this contract. We will bill your primary insurance company as a courtesy to you. In order to properly bill your insurance company we require that you disclose all insurance information including primary and secondary insurance, as well as, any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately.

Participating Insurances
If your insurance plan is one with which we are not a participating provider, you will be responsible for payment in full. However, as a courtesy, we will file your initial insurance claim and if not paid within 30 days you will be responsible.

Referrals and Pre-authorizations
Certain health insurances (HMO,POS, etc.) require that you obtain a referral or prior authorization from you Primary Care Provider (PCP) before visiting a specialist. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower or no payment from the insurance company, and the balance will be your responsibility. Alternative payment arrangements or rescheduling of your appointment may be necessary if not obtained.

Self-pay Accounts
Self-pay accounts are patients without insurance coverage, patients covered by insurance plans in which our practice does not participate, or patients without an insurance card on file with us. It is always the patients' responsibility to know if our office is participating with their plan. Payment in full is due on the day of service for all self-pay patients unless other arrangements have been made in advance with the billing coordinator.

Workers' Compensation
It is the patient's responsibility to provide our office staff with employer authorization/contact information regarding a workers' compensation claim. If the claim is denied by the workers' compensation insurance carrier, it then becomes the patient's responsibility. At your request, we will submit the claim to your primary medical insurance carrier with a copy of the workers' compensation insurance denial. If your primary medical insurance carrier's claim is denied, you will be responsible for payment in full.

Cancellation of Appointments
If it is necessary to cancel a scheduled appointment, we require at least 24 hours advance notice.

Returned Checks
The charge for a returned check is $40 payable by cash or money order. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash only basis following any returned check.

Minors
The parent(s) or guardian(s) is responsible for full payment and will receive the billing statements. A signed release to treat may be required for unaccompanied minors.

Outstanding Balance Policy
It is our office policy that all past due accounts be sent two statements. If payment is not made on the account, a single phone call will be made to try to make payment arrangements. If no resolution can be made, the account will be sent to the collection agency, or attorney, and possible discharge from the practice.

In the event an account is turned over for collections, the person financially responsible for the account will be responsible for all collections costs including attorney fees and court costs.

Regardless of any personal arrangements that a patient might have outside of our office, if you are over 18 years of age and receiving treatment, you are ultimately responsible for payment of the service. Our office will not bill any other personal party.

This financial policy helps the office provide quality care to our valued patients. If you have any questions or need clarification of any of the above policies, please feel free to contact us.

TRAVERSE CITY EYE CONSULTANTS P.C. RESERVES THE RIGHT TO CHANGE AND/OR MODIFY THE INFORMATION ON THIS SITE AT ANY TIME

I have read and understand the above financial policy and agree to the terms detailed within.

_____ _____
Signature of Patient/ Responsible Party **Date**

_____
Printed Name of Patient

Notice and Acknowledgement of Privacy Practices

I acknowledge that I have been offered a copy of Traverse City Eye's Privacy Practices. This policy is available to me upon request at any time. This notice describes in detail how my protected health information will be used and disclosed. It also discusses my rights and our duties with respect to my protected health information. I have the right to review this notice before signing this acknowledgment.

I authorize the following individuals to receive and discuss information regarding my personal health information (general information, surgical and billing):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

This authorization is valid until: _____, 20_____.

I hereby authorize Traverse City Eye to obtain or release any and all pertinent information regarding my medical care, as needed, to assist in my ongoing treatment to or from other health care providers, laboratories, radiology facilities or other institutions.

I have reviewed the aforementioned information and provide my consent regarding any and all disclosures as stated above. I understand that I can revoke this authorization at any time by sending a written revocation to:

HIPAA Privacy Officer
Traverse City Eye Consultants, P.C.
5199 N. Royal Dr.
Traverse City, MI 49684

Patient Signature: _____ Date: _____