MILLMAN-DERR CENTER FOR EYE CARE

Please take a few moments to fill out the following information. **Please be prepared to present your Insurance Card(s) and Driver's License or States ID with these forms. Along with a list of your Current Medications including eye drops, vitamins, and supplements, you may be taking.**

PLEASE PRINT

How were you referred to our office?_______________________________________

Patient Name:____

Last Name First Name Middle Initial

Parent/Guardian Name:____

Street Address:____

City:_____________________________ State:_________________ Zip:____________

Home #: __________________Work #___________________Cell #_______________

Date of Birth: ________________ Current Age: ______ SSN#: ___________________

Sex: M ☐ or F ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐

Email Address: ____

Patient Employer: ____

Occupation: ____

Patient Primary Care Physician: ____

Phone #: ________________________ Fax #: ________________________

Other Physician(s) you would like a letter sent to. Please include Phone and Fax #

____

Emergency Contact: ________________________________ Phone #: ______________

Relationship ___________________________________

____

Patient/Parent or Guardian Signature Date

Updated 8-13-20

MILLMAN-DERR CENTER FOR EYE CARE

AUTHORIZATION
RESPONSIBLE PARTY AGREEMENT
SIGNATURE UPDATE

I hereby authorize my insurance company to pay directly, Millman-Derr Center for Eye Care and/or M.D. Optical proceeds of any benefits due me. I further authorize Millman-Derr Center for Eye Care and/or M.D. Optical to release medical information about me to my insurance company in connection with the processing and payment of my claim.

I acknowledge and understand that I am responsible for any and all charges for services rendered to me. If for any reason any portion of my bill is not paid by my insurance company, I further agree to make satisfactory arrangements.

If my insurance company requires a referral, I understand that I am responsible for obtaining the referral before receiving treatment. If I fail to provide a referral, I will be responsible for all charges incurred. A copy of this can be considered as an original for insurance purposes.

______________________________ ______________________

Print Name Date

____

Signature

Revised Feb 2019

MILLMAN-DERR CENTER FOR EYE CARE

Patient Information (Please Print):

Name______________________________________ Date of Birth___________________

Address____

Release my Medical Information:

I hereby authorize you to release any information including the diagnosis and records of any treatment of examination rendered to me during the period _________to________.

Release From:

Name____

Address____

____

Phone:______________________________ Fax:__________________________________

Send To:

Name____

Address____

____

Phone:_____________________________________ Fax:__________________________

By my signature I authorize release of medical records

Signature____

Records Needed by: ______________ Pickup:_______ Fax:______ Send: ___________

Completed By ____

375 Barclay Circle, Rochester Hills, MI 48307 (248) 852-3636 Fax (248) 852-3631

17900 23 Mile Rd., Ste.100, Macomb, MI 48044 (586) 416-1544 Fax (586) 416-1545
1(800) 652- EYES Michigan Only

MILLMAN-DERR CENTER FOR EYE CARE

MEDICARE PART B AUTOMATED INPUT
“ONE TIME AUTHORIZZATION AGREEMENT”
STATEMENT TO PREMIT PAYMENT OF MEDICARE BENEDITS
TO PROVIDER, PHYSICIAN AND PATIENT

I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished me by this provider. I authorized, any holder of medical or other information about me, to release to the health care financing administration and its agents any information needed to determine these benefits for related services.

MEDIGAP AUTHORIZATION

I am giving Millman-Derr Center for Eye Care and/or M.D. Optical permission to ask for Medigap payments for my medical care.

I understand that if my insurance needs information about me and my medical condition to make a decision about these payments, I give permission for that information.

I request that payment of authorized Medigap benefits be made either to me or on my behalf to Millman-Derr Center for Eye Care and/or M.D. Optical for any services furnished me by that physician/supplier. I authorize, any holder of medical information about me, to release, to my insurance, any information needed to determine these benefits payable for related services.

EYE EXAMS

Medicare B covers physicians services performed in conjunction with treatment of a disease of the eye such as glaucoma or cataracts. If a beneficiary sees an ophthalmologist or optometrist because of a complaint or symptoms of an eye disease or injury, the services are covered even if the visit results only in prescribing of eye glasses.

EYE REFRACTION IS NOT COVERED BY MEDICARE

If Medicare Part B denies payment, I understand that I am responsible of all charges incurred.

________________________________ ____________________

Print name Date

____

Signature

MILLMAN-DERR CENTER FOR EYE CARE

NOTICE OF OUR HEALTH INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCES TO THIS INFORMATION.
PLEASE REVIEW CAREFULLY.

Millman-Derr & Affiliates Health Information Practices

Each time you visit a healthcare provider, a record is made of your visit. Typically, this record contains your health history, current symptoms, examination, test results, diagnosis, treatment, and a plan for future care or treatment.
This information, often referred to as your medical record, services as a:

- Basis for planning your care and treatment
- Means of communication among health professionals providing your care
- Legal document describing the care you received
- Foundation for verifying that you received services billed for
- Source of information for public health issues
- Source of data for facility planning and marketing
- Tool for accessing and improving the care we provide
- Resource for obtaining health benefits and appropriate healthcare placement

Your Health Information Rights

Although your health record is the physical property of Millman-Derr or its affiliates, the information contained in the record belongs to you.

Right to inspect and Copy. You have the right to inspect and obtain a copy of your health record. This right is not absolute and does not include access to data generated by outside organizations or providers. In circumstances where access to the requested information would cause harm to others, we may deny access. To inspect and copy medical information, you must submit your request to the Medical Records Department. We will charge a fee for the cost of copying, mailing or other services associated with your request.

Right to Amend. If you consider the medical information we have about you to be incomplete, you may ask us to amend the information. To request an amendment, your request must be made in writing and submitted to our Medical Records Department. We may deny your request for amendment if it is not in writing or does not provide a reason to support the request. In addition, we may deny your request if the information to be amended:

- Was not created by Millman-Derr or its affiliates
- Is not part of the information which you would be permitted to inspect and copy
- Is accurate and complete

Right to Request Restrictions on Uses and Disclosures. You have the right to request a limit or restriction on the medical information we use or disclose about you for treatment, payment, or healthcare operations. Millman-Derr or its affiliates are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Revoke your Authorization. You the right to revoke your authorization to Millman-Derr or its affiliates to use or disclose health information about you. Your revocation must be in writing and will be honored to the extent that action has already been taken related to use or disclosure.

Right to a Paper Copy of this Notice. The most current Notice of Our Health Information Practices will be posted in visible areas of Millman-Derr and its affiliates. You are entitled to receive a paper copy of notice.

Medical Information Policy

We recognize that medical information about you and your health is personal. We are committed to protecting the record of services that you received at Millman-Derr or its affiliates. This record is needed to provide you with quality care and to comply with certain legal requirements. Your health information will not be used or disclosed without your consent and authorization except as provided by law or otherwise described in this notice.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will make the new version available to you upon request. We are required by law to:

-Assure that medical information that identifies you is kept private;
-Give you notice of our legal duties and practices regarding your medical information;
-Notify you if we are unable to agree to a request restriction;
-Accommodate reasonable requests to communicate information by alternate mean or at alternate locations;
-Follow the terms of the notice that is currently in effect

If you have questions, would like more information, or would like to report concerns, please contact our Office Manager at (248) 852-3636. If you believe your privacy rights have been violated, please request a "Patient Grievance Form". The completed form should be sent to the attention of the Privacy Office, 375 Barclay Circle, Rochester Hills, MI 48307. You may also file a complaint with the Secretary of Health and Human Services. There will no retaliation for filing a complaint.

How We May Use and Disclose Medical Information. The following categories describe different ways that we use and disclose medical information about you. Examples are provided to help clarify each; however, not every use or disclosure within a category will be listed.

For Treatment. We may use medical information about you to provide you with medical treatment. We may disclose medical information about you to staff personnel who will care for you, your personal physician, or any physician or other health care provider rendering health care services to you at Millman-Derr or its affiliates. For example: Members of your healthcare team will record the actions they took and their observations. In that way, the physician will know how you are responding to treatment. We may also provide various reports to your primary physician to assist him or her in subsequent treatment.

For Payment. We may use and disclose medical information about you so that the medical care and services you received may be billed to and payment collected from you, an insurance company or a third party. For example: A bill may be sent to your third-party payer, which identifies you, your diagnosis, treatment, and supplies used. In the event payment is not made, we may provide limited information to collection agencies, attorneys, credit reporting agencies and other organization as is necessary to collect for services renders. We may also provide medical information to assist you in obtaining benefits to which you may be entitled.

For Health Operations. We may use and disclose medical information for healthcare operations. These activates may include operational efficiencies and quality assurance. For example: Members of the medical staff or the risk management and quality assurance committee may us information in your health record to assess the quality care and health outcomes.

Business Associates. Some services are provided at Millman-Derr or its affiliates through contracts with business associates. An example of such a service is anesthesia provided as part of surgery. We disclose health information to our business associates so that can do their job and bill you or your third party payer for services rendered. To protect your health information, however, we require associates to appropriately safeguard your information.

Appointment Reminders and Treatment Alternatives. We may use and disclose medical information to contact your home, office, or other location that you designate to provide a reminder of your appointments or recommend possible treatment alternatives or services that may be in interest to you.

As Required by Law. We will disclose medical information about you when required by federal, state, or local law. Examples of these disclosures are to the Department of Public Health, to law enforcement agencies as required by law or in response to a valid subpoena. We will also release medical information about you to the extent necessary to comply with law related to works compensation.

Health Oversight Activates. We may disclose medical information to a health oversight agency for activates authorized by law. These oversight activites include audits investigations, inspections, and licensure.

MILLMAN-DERR CENTER FOR EYE CARE

NAME:							DATE:			
DOB:							GENDER:			
PRIMARY CARE PHYSICIAN :										
ADDRESS :										
PHONE:										
DO YOU WEAR ANY OF THE FOLLOWING: (PLEASE CIRCLE)										
GLASSES		CONTACT LENSES			GLASSES AND CONTACT LENSES				NONE	
PLEASE CIRCLE ANY EYE CONDITIONS YOU HAVE PRESENTLY OR HAVE HAD IN THE PAST:										
DRY EYES		MACULAR DEGENERATION					GLAUCOMA		CATARACTS	
RETINAL DETACHMENT KERATOCONUS OTHERS (PLEASE SPECIFY):							OTHERS (PLEASE SPECIFY):			
COMMENTS:										
PLEASE CIRCLE ANY EYE CONDITIONS A FAMILY MEMBER OR BLOOD RELATIVE HAVE										
PRESENTLY OR HAVE HAD IN THE PAST:										
DRY EYES		MACULAR DEGENERATION					GLAUCOMA		CATARACTS	
RETINAL DETACHMENT KERATOCONUS OTHERS (PLEASE SPECIFY):										
COMMENTS:										
PLEASE CIRCLE ANY MEDICAL CONDITIONS YOU HAVE PRESENTLY OR HAVE HAD IN THE PAST:										
HIGH BLOOD PRESSURE				HEART PROBLEM			ARTHRITIS		LUNG PROBLEMS	
STROKE		THYROID PROBLEMS					DIABETES		LDL	
ULCERS		CANCER			OTHERS (PLEASE SPECIFY):					
PLEASE CIRCLE ANY MEDICAL CONDITIONS A FAMILY MEMBER OR BLODD RELATIVE HAVE										
PRESENTLY OR HAVE HAD IN THE PAST:										
HIGH BLOOD PRESSURE				HEART PROBLEM			ARTHRITIS		LUNG PROBLEMS	
STROKE		THYROID PROBLEMS					DIABETES		LDL	
ULCERS		CANCER			OTHERS (PLEASE SPECIFY):					

MILLMAN-DERR CENTER FOR EYE CARE

HAVE YOU HAD A FLU VACCINATION:							
NO	YES						
PHARMACY NAME:							
ADDRESS:							
PHONE/FAX:							
PLEASE LIST ALL MEDICATIONS THAT YOU TAKE:							
EYE DROPS:							
GENERAL MEDICATIONS:							
SMOKING STATUS: PLEASE CIRCLE THE STATEMENT THAT APPLIES:							
NEVER		FORMER SMOKER		CURRENT SMOKER			
DO YOU DRINK ALCOHOL:							
NO	YES (***PLEASE SPECIFY):***						
HAVE YOU HAD ANY EYE SURGERIES? (IF YES, PLEASE SPECIFY)							
NO	YES:						
HAVE YOU HAD ANY GENERAL SURGERIES? (IF YES PLEASE SPECIFY)							
NO	YES:						
DO YOU HAVE ANY ALLERGIES:							
ARE YOU PREGNANT OR NURSING? NO YES							

MILLMAN-DERR CENTER FOR EYE CARE