Millman Derr Patient Health Summary Sheet

Date: _____ Pt #: _____

Patient Name: _____ Date of Birth: _____

Primary Family Drs name and address: _____

_____ Fax#: _____

List of Allergies (Medications, Latex, Rubber, Food: _____

_____

_____

Health History (SELF):

	Yes	No
EYE: Glaucoma	___	___
Retinal Detachment	___	___
Lazy Eye	___	___
Macular Degeneration	___	___
Dry Eye	___	___

Previous Surgeries were....Please write the year & the doctors Name.

None: ___

_____

_____

_____

_____

_____

GENERAL HEALTH:	Yes	No
Do you drink ? (Other than socially):	___	___
Asthma	___	___
Emphysema	___	___
High Cholesterol	___	___
High Blood Pressure	___	___
Angina	___	___
Heart Attack	___	___
Irregular Heart Rate	___	___
Pacemaker	___	___
Internal Cardiac Defibrillator		
Any Implanted Electronic Device		
List: _____	___	___
Arthritis: Rheumatoid or Osteo	___	___
Rosacea	___	___

	Yes	No
Do you have a problem with falling?	___	___
Head Injury	___	___
Migraine Headaches	___	___
Type: _____		
TIA/Stroke (Date) _____	___	___
Muscle Weakness/Disease	___	___
List: _____		
Diabetes:	___	___
Date Diagnosed: _____		
Thyroid Problems	___	___
Bleeding/Clotting Problems	___	___
HIV/AIDS	___	___
Lupus	___	___
Sarcoid	___	___
Cancer/ & Location_____	___	___
Date Diagnosed: _____		

Current Medications= Eye Drops Insulin, ALL oral medications and others (how often) and (INCLUDE MG), prescription and non-prescription/Herbal type, Patches etc. *If you have a medication list please give to the front desk so a copy can be made. Medications none: ____

_____

_____

_____

_____

_____

Family History:

	Who	Yes	No
Diabetes	_____	___	___
Glaucoma	_____	___	___
Macular Degeneration	_____	___	___
Retinal Detachment	_____	___	___

Pharmacy Name: _____

FAX: #: _____

Address: _____

Phone # _____

RELEASE OF MEDICAL INFORMATION

May we give your test results or eye condition to a family member if you are not available?

YES ____ NO____

If Yes, please list the name below:

Spouse_____ Other_____

May we leave test results on your voice mail? YES_____ NO _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Millman-Derr Center for Eye Care, P.C.

By signing below, I acknowledge that I have received a copy of Notice of Health Information Practices form.

_____ _____

Patient Signature Date

MD2051
Rev. 10/11

The federal government has mandated new regulations for physician practices regarding electronic prescribing and electronic medical records. These regulations require that we collect the following demographic information from all patients. We are sorry for any inconvenience.

Gender: _____ Male _____ Female

Preferred Language: _____

Race (Choose 1) ___ American Indian or Alaska Native
___ Asian
___ Black or African American
___ Native Hawaiian or Other Pacific Islander
___ White (Caucasian)
___ Other Race

Ethnicity: Hispanic or Latino Yes ___ No___

Smoker: If Yes: ___ Everyday
___ Sometimes

If No: ___ Quit (How long ago)_____
___ Never Smoked

_____ _____
Print Name Date

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

MR#_____

MEDICARE PART B AUTOMATED INPUT

"ONE TIME AUTHORIZATION AGREEMENT"

STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS 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 authorize 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 EXAMINATIONS

Medicare B covers physicians services performed in conjunction with treatment of a disease of the eye such as glaucoma or cataracts. Medicare considers a doctor of optometry to be a physician for all services authorized by state licensure. 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 the prescribing of eyeglasses.

EYE REFRACTION IS NOT COVERED BY MEDICARE

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

_____ _____

Print Name Date

_____

Signature

MD-1054a (Rev. 03/07)

NOTICE OF OUR HEALTH INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS 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 and test results, diagnosis, treatment, and a plan for future care or treatment. This information, often referred to as your medical record, serves 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 officials.
- 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 in writing to our 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 an Accounting of Disclosures. You have the right to request an accounting of uses and disclosures of your medical record not associated with treatment, payment, and healthcare operations. This request must be in writing and pertain to a specific time frame of less than six (6) months. The request must relate to dates after implementation of these rules. (Tentatively set for April 14, 2003).

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 Request Confidential Communications. You have the right to request communication of your health information by alternative means or at alternative locations. For example, you can ask that we contact you only at work or by mail. We will accommodate reasonable requests that are in writing and specify how and where we should communicate with you.

Right to Revoke Your Authorization. You have 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 not 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 the 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 receive 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 requested restriction;
- Accommodate reasonable requests to communicate information by alternate means or at alternate locations, and
- 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 be 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 receive 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 organizations as is necessary to collect for services rendered. 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 activities may include operational efficiencies and quality assurance. For example: Members of the medical staff or the risk management and quality assurance committee may use information in your health record to assess the quality of 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 they can do their job and bill you or your third party payer for services rendered. To protect your health information, however, we require the business 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 to recommend possible treatment alternatives or services that may be of 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 laws related to workers compensation.

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

M B SURGICENTER

Language Assistance Services

English
ATTENTION: If you don't speak English, language assistance services, free of charge, are available to you. Call 248-852-3636

Español (Spanish)
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 248-852-3636

العربيـــــة (Arabic)
بـــرقم اتصـــل .بالمجـــان لـك تتوافـــــر ةىاللغـــو المســـاعدة خدمات فـــإن ،اللغـــة اذكر تتحـــدث كنـت إذا :ملحوظـة -248-852-3636n (رقـم

Deutsch (German)
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 248-852-3636

Polski (Polish)
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 248-852-3636

Français (French)
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 248-852-3636

Italiano (Italian)
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 248-852-3636

ܐܬܘܪܝܐ (Assyrian)
[illegible] 248-852-3636

繁體中文 (Chinese)
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 248-852-3636

한국어 (Korean)
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 248-852-3636

Shqip (Albanian)
KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 248-852-3636

Tagalog-Filipino
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 248-852-3636

Tiếng Việt (Vietnamese)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 248-852-3636

Русский (Russian)
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 248-852-3636

日本語 (Japanese)
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。248-852-3636

λληνικά (Greek)
ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 248-852-3636