Greenberg Laser Eye Center
3001 W. Big Beaver Rd., Ste. 105, Troy, MI 48084
(248) 649-2820 Fax: (248) 649-1444
Corner of Coolidge
Across from Somerset Mall

Welcome to Greenberg Laser Eye Center. Thank you for choosing us.

As you are a new patient here, we would like to inform you of a few things in preparation for your appointment:

- Please bring with you:
  - **Completed paperwork** or if you prefer you can email or fax it to our office in advance.
  - All **insurance cards** including medical insurance cards
  - **All eyeglasses (prescription glasses and any store bought pre-made eyewear)**
  - **All contact lenses including contact lens packaging with specifications**
  - A list of your medications

- Please allow **1½ hours** for your complete eye exam.
  Dr. Greenberg will perform a dilated medical examination of your eyes. If you wear contact lenses or are interested in being fit for contact lenses please allow at least **2 hours** for your exam.

- Dr Greenberg is a medical doctor and surgeon who is able to see and treat medical conditions of the eyes. Some examples are arthritis, diabetes, dry eyes and glaucoma. If you have a medical eye condition your medical insurance will be billed for the visit.

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(248) 649-2820 fax (248) 649-1444 www.greenbergeye.com vision@greenbergeye.com

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Telephone #: Home: ( ) _____ Work: ( ) _____
Date of Birth: _____ Age: _____ Cell: ( ) _____
Gender: M ☐ F ☐ Marital Status: ☐ S ☐ M ☐ D ☐ W
Social Security #: _____
Personal Email: _____
Occupation: _____
Employer: _____
Address: _____ Telephone#: ( ) _____
City: _____ State: _____ Zip: _____
Financially Responsible Person: _____ Telephone#: ( ) _____
Address: _____ City: _____ State: _____ Zip: _____
Employer: _____
Name of nearest relative not living with you: _____
Address: _____ Telephone#: ( ) _____
Family Physician: _____ Telephone#: (_____) _____

Whom may we thank for referring you to our office?
Name _____

Address _____

1. When was your last eye exam? _____ Last Dr.: _____
2. How many pairs of glasses do you have? _____ How many do you use? _____
3. Do you wear contact lenses? ☐ Yes ☐ No
Brand: _____ Prescribed by: _____

To comply with the Affordable Care Act, we are required to ask you the following questions:

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ African American ☐ Caucasian
☐ Native Hawaiian or Other Pacific Islander Other _____

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Preferred Language: ☐ English ☐ French ☐ Italian ☐ Japanese ☐ Portuguese ☐ Russian ☐ Spanish

Primary Care Doctor: _____

Endocrinologist: _____ Rheumatologist: _____

Pharmacy Name: _____ Pharmacy Phone#: _____

Pharmacy location (Street & City): _____

HIPAA -This office complies with the most recent HIPAA Privacy and Security Act. I have been offered a copy of the Notice of Privacy Practices.

Do we have your permission to address you by your last name in the waiting room? ☐ **Y** ☐ **N**
Do we have your permission to leave a message at the given numbers regarding appointments? ☐ **Y** ☐ **N**
Do we have your permission to leave a message at the given numbers regarding billing questions? ☐ **Y** ☐ **N**
Do we have your permission to leave message/mail/email/text you about appointments/reminders? ☐ **Y** ☐ **N**

I hereby authorize the release of any medical information necessary to process this claim. I understand I am responsible for payment of all copays, deductibles, or non-covered procedures.

Signed: _____ Relationship: _____ Date: _____

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MEDICAL HISTORY

Name: _____ Date of Birth:_____ Today's Date: _____

Allergies: Reaction Severity

☐Sulfa mild/moderate/severe
☐Penicillin mild/moderate/severe
☐Aspirin mild/moderate/severe
☐Codeine mild/moderate/severe
☐Cipro mild/moderate/severe
_____ mild/moderate/severe
_____ mild / moderate / severe
_____ mild / moderate / severe

Current Eye Medications: (Please list)

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

All Medications (other than eye): (Please list) + directions/dosage (mg)

_____ _____ _____ _____
_____ _____ _____ _____

Vaccines last 12 months: Flu?☐Yes☐No Pneumonia?☐Yes☐No

Have you been on a medication for a prostate condition? ☐Yes ☐No

Systemic Illnesses / Infections/ Medical Diagnoses:

☐No history of illnesses
☐Anemia
☐Arthritis
☐Arrhythmia
☐Asthma
☐Bleeding Disorder
☐Cancer_____
☐Congestive Heart Failure
☐COPD
☐Diabetes
☐Eczema
☐Fibromyalgia
☐Headache
☐Hepatitis A / B / C
☐Herpes (including cold sores)
☐High Blood Pressure
☐ High Cholesterol
☐Histoplasmosis
☐Herpes Zoster (shingles)
☐HIV / AIDS
☐Kidney Disease
☐Kidney Stones
☐Liver Disease
☐Lupus
☐Meningitis
☐Migraine
☐MRSA
☐Multiple Sclerosis
☐Polymyalgia
☐Psychiatric Disorders
☐Rheumatoid Arthritis
☐Sjogren's
☐Stroke
☐Syphillis
☐Thyroid Disease circle: Hypo / Hyper
☐ Toxoplasmosis
☐ Wound Infection

Other_____

Past Eye History: (Please mark all that apply)

☐Overall Healthy
☐Aphakia
☐Cataracts
☐Cataract Surgery
☐Contact Lens Intolerance
☐Corneal Infection
☐Diabetic Retinopathy
☐Dry Eyes
☐Glaucoma
☐Hyperopia (Far sighted)
☐Iritis
☐Keratoconus
☐Lazy eye – patched / surgery
☐Macular Degeneration
☐Myopia (Nearsighted)
☐Optic Neuritis
☐Retinal Detachment
☐Trauma

Other_____

Please continue on the back side of this page →

General Surgeries / Operations: (Please list)

_____

_____

Eye and Eyelid Surgeries (including cosmetic procedures):

☐ No prior eye surgery

Please list all eye surgeries including cosmetic procedures with dates_____

_____

Family History:

☐ Blindness
☐ Cataracts under 50 years old
☐ Glaucoma relation?_____living or deceased
☐ Lazy Eye
☐ Macular Degeneration
☐ Retinal Detachment

Other_____

Social History: (Please mark all that apply)

Smoking: ☐ current every day smoker ☐ current some day smoker ☐ former smoker ☐ never smoked

Alcohol Use: ☐ Yes ☐ No If yes how much and how often?_____

Drug Use: ☐ Yes ☐ No If yes what and how often?_____

Review of Systems: (Please mark all that apply)

Eyes
- ☐ Previous Surgery
- ☐ Contact Lens
- ☐ Double Vision
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Macular Degeneration
- ☐ Dry Eyes
- ☐ Flashes
- ☐ Floaters

Ear, Nose, and Throat
- ☐ Hard of Hearing
- ☐ Ringing in Ears
- ☐ Vertigo

Cardiovascular
- ☐ Chest Pain
- ☐ Dizziness
- ☐ Fainting Spells
- ☐ Shortness of Breath
- ☐ Irregular Heart Beat
- ☐ Difficulty Lying Flat

Constitutional
- ☐ Fatigue / Weakness
- ☐ Fever
- ☐ Weight Gain / Loss

Respiratory
- ☐ Cough
- ☐ Congestion
- ☐ Wheezing
- ☐ Asthma

Gastrointestinal
- ☐ Heartburn
- ☐ Nausea / Vomiting
- ☐ Jaundice / Hepatitis

Genito-Urinary
- ☐ Pain / Difficulty
- ☐ Blood in Urine
- ☐ History of Kidney **Stones**
- ☐ History of STD's

Psychiatric
- ☐ Anxiety / Depression
- ☐ Mood Swings
- ☐ Difficulty Sleeping

Endocrine
- ☐ Increased Thirst
- ☐ Increased Hunger
- ☐ Increased Urination
- ☐ Increased Sweating
- ☐ Fingernail Changes

Blood / Lymphnodes
- ☐ Easy Bruising
- ☐ Gums Bleed Easy
- ☐ Prolonged Bleeding
- ☐ Heavy Aspirin Use

MusculoSkeletal
- ☐ Stiffness
- ☐ Arthritis
- ☐ Joint Pain / Swelling

Skin
- ☐ Rash / Sores
- ☐ Lesions
- ☐ Hives / Eczema

Neurological
- ☐ Seizures
- ☐ Weakness / Paralysis
- ☐ Numbness
- ☐ Tremors

Immunologic
- ☐ Hives
- ☐ Itching
- ☐ Runny Nose
- ☐ Sinus Pressure

FINANCIAL POLICY AND BILLING PROCESS
GREENBERG LASER EYE CENTER

- **Copay, Co-insurance and Deductibles:** It is my responsibility to know what my copay, co-insurance and deductibles are, and my obligation to pay this at the time of service. If I am not able to pay my co-pay, deductible or coinsurance portion at the time of service my appointment may be rescheduled or subject to a $15.00 fee. If I receive 3 statements or more, there will be a statement fee of $20.00 added to my account for each additional statement received.
- **No Show Appointments:** All appointments that are not canceled within 48 business hours of the appointment time are subject to a $39.00 fee. This $39.00 fee must be paid before we can reschedule your appointment.
- **Refractions:** Refraction is the process of determining if there is a need for corrective eyeglasses. It is an essential part of an eye examination and necessary in order to write a prescription for glasses or contact lenses. Medicare and most medical insurances do not cover this service. I understand that I am responsible for this $36.00 fee due at the time of service.
- **Contact lens fitting:** There is a $120.00 contact lens fitting fee charge for first time wearers and a $65.00 charge for an established wearer.
- **Insurance Coverage:** I acknowledge that the insurance cards I have presented are current and accurate. If we have not received payment after 90 days, our office reserves the right to send the entire bill to the patient for payment. It will be your responsibility at that point to contact your insurance company with any questions or concerns regarding your bill.
- **Medical vs Vision:** Your **medical insurance** is billed if a medical condition is discovered during your examination.
    - Evaluation of an ocular disease you have been diagnosed with (e.g., glaucoma, cataract, corneal, or retinal disease). A complaint such as redness, tearing, burning, or other pain or discomfort to the eyes.
    - A history of or new onset of floaters, flashes of light, or other visual disturbance.
    - To follow an existing chronic condition such as diabetes, corneal disease, dry eye syndrome, blepharitis and autoimmune disease, or if you take high risk medications like Plaquenil.
    - If you are scheduled for additional testing such as visual field, OCT, or retinal photography.
    - If your visit requires a report to your primary care physician.

- **Participating Insurance Plans:** If GLEC is not a participating provider in my insurance plan, I will be responsible for filing my own claims and I will be responsible for paying in full at the time of service.
- **Non-covered Services:** I understand that some services may be considered non-covered services by my insurance plan. I understand that it is my responsibility to know what my insurance does or does not cover and I understand that I am financially responsible for paying all non-covered services.
- **Denied Charges:** I understand that some charges may be denied by my insurance carrier as investigational, experimental or not medically necessary and will not be paid by my insurance carrier. I understand that my physician feels these services are needed whether my insurance carrier deems them payable or not and that I am obligated to pay for these services in full.
- **Returned Checks & Past Due Accounts:** Returned checks will be subject to collection charges of an additional $25.00 with penalties and interest. All accounts are considered past due if not paid within 90 days of service. Past due accounts may result in collection turnover and be subject to penalties and interest, or the refusal of future appointments until old balances have been paid in full. The practice does not accept post dated checks.
- **Surgery Charges:** The practice will make every effort to determine your insurance benefits and to relay to you what you will owe for surgery charges, please keep in mind that this is just an estimate. Please be aware that when surgery is performed, you may incur additional charges (in addition to the surgeon's fees) from the surgery facility, anesthesiologist, laboratory or radiologist.

X_____

Patient/Representative Signature Date

Printed Name _____

AUTHORIZATION TO RECEIVE/RELEASE HEALTH INFORMATION

Greenberg Laser Eye Center

3001 West Big Beaver, Suite 105

Troy, MI 48084

Due to the **HIPAA Compliance Privacy Laws of the Federal Government**, it is mandatory that we ask you to review and answer the following questions listed below.

Name of Patient: _____

Do you have any particular person or family members that you authorize to receive and discuss information regarding your personal health information (general medical information, surgical and billing)?

◯Yes ◯No If yes, please provide:

Name: _____

Relationship: _____

Phone Number: _____

Alternate Number: _____

Is this person your Power of Attorney for medical purposes? ◯**Yes** ◯**No**

Name: _____

Relationship: _____

Phone Number: _____

Alternate Number: _____

I hereby authorize the above person 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. **This authorization remains in effect until revoked**.

I have reviewed the aforementioned information and provide my consent regarding any and all the issues as stated above.

I have reviewed the Notice of HIPAA Privacy Policy. A copy of this policy will be provided to me upon request.

Patient Signature: _____

Date: _____