Greenberg Laser Eye Center Established Patient Update Form

Please fill in all of the information below for the patient being seen today.

Today's Date:_____

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

Marital Status: ☐ S ☐ M ☐ D ☐ W **Name Change**:☐ Y ☐ N

Address:_____**City**:_____**Zip**:_____

Preferred Phone:_____**Work**:_____**Other**:_____

Cell ☐ Home ☐ **Cell ☐ Home ☐**

Email:_____ (**We do not share your information)**

***Emergency Contact Name:**_____

***Emergency Contact Phone:**_____ **(Cannot be the same as above numbers)**

***Relationship to Patient:**_____

***I authorize Greenberg Laser Eye Center to release my records and any information to the above individual**
_____YES _____NO

Family Doctor:_____ **City:**_____
First Last
Rheumatologist:_____**Endocrinologist**:_____

Neurologist:_____**Cardiologist:**_____

Medical Insurance: ☐**Aetna** ☐**BCBS** ☐**BCN** ☐**CIGNA** ☐**Cofinity** ☐**HAP HMO** ☐**HAP Preferred** ☐**Medicare** ☐**Medicare Plus Blue** ☐**Priority Health** ☐**Total Healthcare** ☐**Total Healthcare HMO** ☐**UMR** ☐**United Healthcare** **Other**:_____

Primary Subscriber Name: _____

Date of Birth:_____**Employer**:_____**Employer Phone**:_____

Vision Insurance: ☐**BCV** ☐**DAVIS** ☐**Eyemed** ☐**NVA** ☐**Optum Health** ☐**UMR** ☐**VSP**
Other:_____

Primary Subscriber Name: _____***Last 4 digits of SS:**_____

Date of Birth:_____**Employer**:_____**Contact Phone**: _____

Signature:_____(if under 18 parent or legal guardian)

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 co-insurance portion at the time of service my appointment may be rescheduled or subject to a $15.00 fee.
- **No Show Appointments:** All appointments that are not cancelled within 48 business hours of the appointment time are subject to a $40.00 fee. This $40.00 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 $60.00 charge for an established wearer.
- **Insurance Coverage:** I acknowledge that the insurance cards I have presented are current and accurate.
- **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, an 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 carriers 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 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

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: _____