Patient Registration Form

Lawrence Handler, MD **Zachary Pearce, DO** **William Ehrlich, MD** **Carine Meldrum, PA-C**

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INFO

Last name: _____ First Name: _____ Middle Initial: ___

Address: _____ City: _____ State: ____ Zip: _____

Date of birth: _____ Age: ____ SSN #: _____ Sex: ☐ M ☐ F ☐ _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated

Cell: _____ Work: _____ Email: _____

Emergency Contact: _____ Phone: _____

INSURANCE

☐ Self Employed

Primary Insurance: _____ Employer: _____

☐ Spouse Name: _____ D.O.B. _____

Secondary Insurance: _____

☐ Spouse Name: _____ D.O.B. _____

Workman's Comp:

Adjuster's Name: _____ Claim #: _____

PHARMACY INFO

Name of Pharmacy: _____ Phone: _____

Street Name and City _____

WHO REFERRED YOU TO OUR PRACTICE?

Referring Physician: _____Phone: _____

Fax: _____

Who is your Ophthalmologist/Optometrist? _____

Phone: _____ Fax: _____

Who is your Primary Care Physician? _____

Phone: _____ Fax: _____

Who is your Cardiologist? _____

Phone: _____ Fax: _____

Who is your Pulmonologist? _____

Phone: _____ Fax: _____

Who is your Endocrinologist? _____

Phone: _____ Fax: _____

ASSIGNMENT OF INSURANCE BENEFITS

****It is important that you read and sign your name at the bottom of the page**

Medicare Lifetime Assignment of Benefits:

I request that payment of authorized Medicare benefits be made on my behalf to Lawrence Handler MD, Zachary Pearce DO, William Ehrlich MD, and Carine Meldrum PA-C for any services furnished to me by the listed providers. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier. This assignment is effective until evoked by me in writing.

Medi-gap (Medicare Supplemental Insurance) Assignment of benefits:

I request that payment of authorized Medi-gap benefits to be made to the Provider(s) and authorize any holder of medical information about me to release to the Medi-gap insurer any information needed to determine benefits payable for services from the Provider(s). This assignment is effective until evoked by me in writing.

General (Commercial Insurance) Assignment of Benefits:

I request that payment of authorized insurance benefits be made on my behalf to the Provider(s) for any equipment or services provided to me by those organizations. I authorize the release of any medical or other information to my insurance company to determine the benefits payable for the services rendered by the Provider(s)

I understand that I am financially responsible to the Provider(s) for any charges not covered by my health benefits. It is my responsibility to notify the Provider(s) of any changes in my healthcare coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill if the submitted claim or any part of it are denied payment. **It is my responsibility to understand my insurance benefits and plan coverage. I accept financial responsibility for payment for all services or products received.**

By signing this document, I understand and agree with the **Assignment of Benefits** listed above.

_____ _____

Print name Date

_____ _____

Signature Date

NAME: _____ **DATE:** _____

1. Please check the box pertaining to any problem you currently have or have experienced.

Allergic/Immunologic ☐ Allergies/hay fever	**Hematologic/Lymphatic** ☐ Anemia ☐ Bleeding problems ☐ Breast cancer	**Neurology** ☐ Headaches ☐ Migraine ☐ Seizures
Cardiovascular ☐ Arteriosclerosis ☐ Defibrillator ☐ Heart Disease ☐ High Blood Pressure ☐ High Cholesterol ☐ Pacemaker	**Psychiatric** ☐ Anxiety ☐ Depression	**Respiratory** ☐ Asthma ☐ Sleep Apnea ☐ Bronchitis ☐ Emphysema ☐ CPAP ☐ Oxygen
Ear/Nose/Mouth/Throat ☐ Dry throat/mouth ☐ Sinus congestion	**Integumentary (Skin/breast)** ☐ Cancer ☐ Easy bruising ☐ Rash	**GI Tract** ☐ Crohn's disease ☐ Reflux ☐ Ulcer
Endocrine ☐ Diabetes ☐ Lupus ☐ Myasthenia Gravis ☐ Thyroid disease	**Musculoskeletal** ☐ Rheumatoid arthritis ☐ Muscle/joint pain	**Other:** ☐ _____ ☐ _____

2. COMPLETE THE FOLLOWING BELOW:

Have you had exposure to HIV, AIDS, or Hepatitis? ☐ YES ☐ NO
Are you HIV/AIDS positive? ☐ YES ☐ NO
Are you currently pregnant? ☐ YES ☐ NO
Do you have visual difficulties when driving? ☐ YES ☐ NO

3. Are you experiencing any of the following problems with your eye? Check box if "Yes"

☐ Bell's Palsy	☐ Blurred vision	☐ Burning	☐ Cataracts	☐ Cataract surgery
☐ Chronic infection of the eye	☐ Chronic infection of the eyelid	☐ Corneal transplant	☐ Crossed eyes	☐ Double vision
☐ Drooping eyelid	☐ Dryness	☐ Eyelid lid surgery	☐ Eye muscle surgery	☐ Eye pain/soreness
☐ Excess tearing/ watering	☐ Facial Botox	☐ Facial surgery	☐ Facial twitching or spasms	☐ Flashes
☐ Floaters in vision	☐ Foreign body sensation	☐ Fuchs	☐ Glaucoma	☐ Glare
☐ Halos	☐ Itching	☐ Lasik eye surgery	☐ Lazy eye	☐ Light sensitivity
☐ Loss of vision	☐ Loss of side vision	☐ Macular degeneration	☐ Mucous discharge	☐ PRK
☐ redness	☐ Retinal detachment	☐ RK surgery	☐ Sandy or gritty feeling	☐ Sjogren's
☐ Styes or chalazion	☐ Tired eyes	☐ Other:		

4. Past Surgical and Medical Conditions – Check box if any apply to you.

☐ Appendix surgery	☐ A-fib	☐ Ankle/foot surgery	☐ Brain surgery	☐ CABG/Bypass/sent
☐ Carpal Tunnel surgery	☐ Cervical/Thoracic/Lumbar surgery	☐ Defibrillator	☐ DVT	☐ Gallbladder surgery
☐ Gastric Bypass surgery	☐ Hernia surgery	☐ Hip replacement	☐ Hysterectomy	☐ Knee replacement/surgery
☐ Mastectomy	☐ Myocardial Infraction/ Heart attack	☐ Ostomy	☐ Pacemaker	☐ Shoulder/rotator cuff surgery
☐ Sinus surgery	☐ Stroke/TIA	☐ Thyroidectomy	☐ Tonsillectomy	☐ Other:

NAME: _____ DATE: _____

ANSWER THE FOLLOWING

Latex allergy? □ No □ Yes, Reaction: _____

Tape allergy? □ No □ Yes, Reaction: _____

Epinephrine allergy? □ No □ Yes, Reaction: _____

Has your eye doctor told you that you're a steroid responder? □ No □ Yes, Reaction: _____

Are you allergic to any medications? □ No □ Yes, **list below**:

Medication drug allergies	Reaction

If you take or use any prescription medication/ointments/eye drops, list below:

Medication	Dosage	How often	Reason

List any non-prescription medications (OTC's) and eye drops below:

Name	Dosage	How often	Reason

Patient Social History

Please answer the following:

Do you smoke or chew tobacco? ☐ No ☐ Former/Year quit: _____

☐ Yes → packs per day: ☐ ½ pack ☐ 1 pack ☐ 2 packs ☐ 3 packs

Do you use marijuana? ☐ No ☐ Yes → how often? ☐ Rarely ☐ Occasionally ☐ Frequently

Do you use e-cigarettes/vapes? ☐ No ☐ Yes → how often? ☐ Rarely ☐ Occasionally ☐ Frequently

Do you drink alcohol? ☐ No ☐ Yes → how often? ☐ Rarely ☐ Occasionally ☐ Frequently

PLEASE CHECK BOX IN EACH CATEGORY

Race

- ☐ American Indian or Alaska
- ☐ Asian
- ☐ Black or African American
- ☐ White
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ Other: _____
- ☐ Unknown
- ☐ Declined

Ethnicity

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Unknown
- ☐ Declined

Preferred Language

- ☐ English
- ☐ Spanish
- ☐ Other: _____
- ☐ Declined

Our office has implemented electronic health records. Because of this, you are required to complete the information below. The Government has mandated we request the following information on each of our patients.
Meaningful Use is the name of a new nationwide initiative to improve the health of our nation. As part of this initiative, Michigan Oculofacial Specialists is required to gather information for compliance to Meaningful Use guidelines. Part of this information includes adding patients' race, ethnicity, and preferred language to our electronic health record. The government requires this information to better identify possible disparities in access and quality of healthcare based on race and ethnicity on a national level.

Family Medical History

	Name	Age or Deceased	Conditions or diseases	If deceased, cause of death/age
Mother:	_____	_____	_____	_____
Father:	_____	_____	_____	_____

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my health. I also understand it is my responsibility to inform the doctor of any changes in my medical status. I also authorize the health care staff to perform the necessary services I may need

OCCUPATION: _____

_____ _____
Print name Date

_____ _____
Signature Date

Confidential Communications Preferences

LAWRENCE HANDLER M.D. | ZACHARY PEARCE D.O. | WILLIAM EHRLICH M.D. | CARINE MELDRUM PA-C

Our current Notice of Privacy Practices allows us to call, text, and or email you with a courtesy reminder regarding upcoming appointments. In some cases, it may be necessary to contact you by telephone to discuss other medical information. If you are unavailable, we would like to be able to leave you a detailed message (e.g., lab results, x-rays, and other test results).

Please read the following choices and tell us whether we can leave a detailed message regarding the above-mentioned information on an answering machine, cell phone and/or with any specific individuals you designate below.

Choose one of the following:

☐ **I consent and authorize** Lawrence Handler MD, Zachary Pearce DO, William Ehrlich, Carine Meldrum PA-C, and/or staff to leave a telephone detailed message regarding my medical care or my minor child at the following numbers:

Cell Phone _____ Initials _____

Work/Other Phone _____ Initials _____

Home answering machine _____ Initials _____

☐ **I consent and authorize** Lawrence Handler MD, Zachary Pearce DO, William Ehrlich MD, Carine Meldrum PA-C, and/or staff to disclose verbally any results or instructions to the following specified person(s) who are at least 18 years or older and who may answer the above phone number(s) in my absence.

Designated Person Name: _____ **Relationship**: _____

Designated Person Name: _____ **Relationship**: _____

☐ **I do not consent or authorize** detailed messages regarding my medical care to be left on my answering machine, cell phone, or with a designated person. I wish to be contacted personally. I understand that there may be a delay in receiving my results.

****This communication preference will remain in effect for indefinitely or unless you rescind or provide a change.**

CONSENT TO PHOTOGRAPH

The undersigned does hereby consent to appear in photographs, videotapes, and/or electronic media to be used by Michigan Oculofacial Specialists and its physicians in conjunction with patient education materials, marketing, or publicity of Michigan Oculofacial Specialists' programs and services in whatever manner my be deemed appropriate and professional. The undersigned also waves the right to compensation for such use of photographs, videotapes, and/or electronic media. **Please choose to accept or decline**:

☐ **Accept** ☐ **Decline**

_____ _____

Printed Name **Date of birth**

_____

Parent/Legal Guardian Name for Minor Patients

_____ _____

Signature **Date**

_____ _____

Witness **Date**

PATIENT FINANCIAL POLICY

Our practice is committed to building a successful physician relationship with you and your family. Therefore, we believe that communicating our financial policy is a good healthcare practice and an essential part of this relationship. Your insurance coverage is a contract between you and your insurance company, not your insurance company and us. We will file your primary and secondary insurances as a courtesy. Please realize that having secondary insurance does not necessarily mean that your services are covered 100%. Secondary insurances typically pay according to a coordination of benefits with primary insurance. It is your responsibility to provide us with accurate insurance information and to inform us of any changes in your coverage as they occur.

Co-Pay, Co-Insurance, Deductibles:

To become a "Provider" of medical services through certain health plans, Dr. Lawrence Handler, Dr. Zachary Pearce, Dr. William Ehrlich, and Carine Meldrum PA-C are required to enter into a contract with these insurance companies. Because of this agreement, you will be responsible for all copays, coinsurance, and deductibles. We are obliged to collect your copay at the time of service per our contract with your insurance company. **Therefore, all co-payments and prior balances will be collected at the time of your visit. Prior to your office visit, please check with your insurance company to determine if you have a deductible or coinsurance amounts.** We accept exact cash, check, and credit cards (American Express, Visa, Mastercard, Discover, Care Credit). We do not accept post-dated checks. Some patients may accrue large balances for services provided. We will work with these patients to set up a mutually feasible payment plan. Please understand that we cannot waive deductibles, coinsurances, or copays that are required by your insurance. This is a violation of our contract with the insurance plans.

Surgery

If you are scheduled for surgery with Dr. Lawrence Handler, Dr. Zachary Pearce, Dr. William Ehrlich, or Carine Meldrum PA-C, you may have out-of-pocket expenses (copays, coinsurance, and deductibles). If so, you will be required to pay for those expenses prior to your surgery. Cosmetic surgical payments will be collected **AT LEAST TWO WEEKS** prior to your surgical date.

Cancellation Fee

A cancellation fee of $25.00 will be applied if your appointment is not cancelled at least 48 hours in advance.

Returned Checks

There will be a returned check charge of $50.00 payable cash, credit card, or money order. This will be applied to your account along with the balance prior to this fee. You will be placed on a cash-only basis following any returned check.

Medical Record Copies

Patients requesting copies of medical records will be charged the following fees. These charges cover the administrative costs of copying and mailing such records:

- $32.00 initial fee and includes one clinic visit
- $61.00 initial fee and first 22 pages

FMLA and other Disability Paperwork

Completing disability, FMLA and other requested supplemental insurance forms requires time away from patient care and day-to-day business operations. Therefore, a pre-payment of $25.00 per form is required. Please understand that to complete forms, your medical record must be reviewed, forms completed and signed by the physician, and scanned into your Electronic Medical Record. Some of these forms can be quite complicated and tedious to fill out. Please provide pertinent information like dates of disability and return to work date. Please allow the office 10-14 business days in which to review your medical record for the information requested and completion of the form.

I, _____, **understand and agree with the above Patient Financial Policy**.
(print name)

Signature: _____ Date: _____