CASTLEMAN EYE CENTER
CHANGING LIVES THROUGH VISION

Snigdha Singh, M.D. **Arezo Amirikia, M.D.**

Dear Patient:

Please fill out the enclosed paperwork and bring it to your exam along with your insurance cards. If your insurance requires a referral or authorization, please bring that with you also. Just a friendly reminder that exam fees and co-pays are collected at the time of your visit. We accept cash, checks and credit cards (VISA, Mastercard and Discover).

We may use dilating drops to examine your eyes and you will be light sensitive with blurred reading vision for several hours after. To alleviate some of the brightness, please bring sunglasses with you.

Castleman Eye Center is now offering **Optomap ultra-wide digital retinal screening** to our patients. This new technology allows us to document a more complete view of the retina (back of the eye) than has previously been possible. This allows for early detection of eye disease and leads to earlier treatment & enables us to better monitor your eye health. Testing is fast, easy & comfortable. However, your insurance plan does not cover this screening. There is an additional fee if you choose to have the Optomap performed during your visit.

APPOINTMENT DATE IS:_____

TIME:_____

We look forward to seeing you and providing your eye care for years to come.

Thank you,

The Doctors and Staff of Castleman Eye Center

13080 Eureka Rd
Southgate MI 48195
Tel: (734) 283-0500
Fax: (734) 283-2720

415 E. Maple Road
Troy, MI 48083
Tel: (248) 813-0099

PATIENT NAME			HOME PHONE#	WORK PHONE#
CELL PHONE#			EMAIL	
ADDRESS			CITY	STATE MI / ZIP
SEX	AGE	BIRTH DATE	MARITAL STATUS S M D W	SOCIAL SECURITY NUMBER

NOTE: The information below is a reporting requirement of the government Patient Protection and Affordable Care Act 2010. We are obligated to obtain this information from our patients.

Race: White American Indian/Alaska Native Asian Black or African American Native Hawaiian or Other Pacific Islander	**Ethnicity:** Hispanic Not Hispanic **Language Preference:** English Other
EMPLOYER:	**OCCUPATION:**
SPOUSE NAME:	**SPOUSE EMPLOYER:**
ER CONTACT:	**PHONE:**

MEDICAL INSURANCE INFORMATION

PRIMARY:	**POLICYHOLDER NAME/BDATE:**
SECONDARY:	**POLICYHOLDER NAME/BDATE:**
TERTIARY:	**POLICYHOLDER NAME/BDATE:**

VISION INSURANCE

Primary	**Secondary**
FAMILY DR:	**ADDRESS/PHONE:**
PHARMACY:	**ADDRESS/PHONE:**

How were you referred to us? Patient/Family Google Internet Optometrist Insurance Location Family Doctor Other

If Referred by Doctor please complete:

NAME:_____

ADDRESS:_____

PHONE: _____

Medical History Questionnaire

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

Email:_____ **Cell Phone:**_____

Allergies (drug, food or substance) & Reaction Severity

_____ _____ mild / moderate / severe

_____ _____ mild / moderate / severe

Past Ocular History: (Please mark all that apply)

□ **No History of Eye Disease**
□ Amblyopia (Lazy eye)
□ Aphakia
□ Astigmatism
□ Cataracts
□ Diabetic Retinopathy
□ Dry Eyes
□ Glaucoma
□ Hyperopia (Far sighted)
□ Iritis
□ Keratoconus
□ Macular Degeneration
□ Myopia (Near sighted)
□ Optic Neuritis
□ Retinal Detachment

Other_____

Eye Surgeries: (Please mark all that apply & list dates)

□ **No Prior Eye Surgery**
□ Blepharoplasty
□ Cataract Surgery_____
□ Corneal Transplant _____
□ Foreign Body Removal
□ Retinal Laser Surgery
□ LASIK _____
□ PRK
□ Glaucoma laser surgery
□ Punctal Plugs
□ RK
□ Strabismus Surgery (eye muscle surgery)
□ Trabeculectomy (Glaucoma surgery)
□ Vitrectomy/Retina Surgery

Other_____

Current Eye Drops (if any): (Please list)

_____

Medical Illnesses (if yes, indicate # of years):

□ **Overall Healthy**
□ Anemia
□ Arthritis
□ Arrhythmia
□ Asthma
□ Bleeding Disorder
□ Cancer
□ Thyroid Disease
□ Herpes/Shingles
□ Toxoplasmosis
□ Congestive Heart Failure
□ COPD
□ Diabetes _____yrs
□ Eczema
□ Fibromyalgia
□ Headache
□ Hearing Loss
□ AIDS/HIV positive
□ Sjogrens
□ Hepatitis A B or C
□ High Blood Pressure _____yrs
□ High Cholesterol
□ Graves Disease
□ Kidney Disease
□ Kidney Stones
□ Liver Disease
□ Lupus
□ Rheumatoid Arthritis
□ Lung Disease
□ Histoplasmosis
□ Migraine
□ Polymyalgia
□ Psychiatric Disorder
□ Skin Cancer
□ Stroke
□ Mult. Sclerosis(MS)

Insulin? Yes_____ No_____ Plaquenil for Rheumatoid Arthritis? Yes_____ No_____

General Surgeries / Operations: (Please list all & dates)

_____

_____

Current Medications: (Please list, including vitamins, supplements)

MEDICATION NAME	DOSE/MG.	HOW MANY PILLS & TIMES PER DAY
EXAMPLE:	*500 MG*	*1 PILL PER DAY*

---Turn over for page 2---

MEDICATIONS CONTINUED:

MEDICATION NAME	DOSE/MG.	HOW MANY PILLS & TIMES PER DAY

Family History (Mother, Father, Siblings, Grandparents):

□ Diabetes □ Stroke □ Blindness □ Macular Degeneration □ Arthritis
□ Cancer □ TB □ Cataracts □ Retinal Disease □ Lazy Eye
□ Heart Disease □ Kidney Disease □ Glaucoma □ High Blood Pressure

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
- □ Pain
- □ 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

CASTLEMAN EYE CENTER
PATIENT FINANCIAL POLICY

Thank you for choosing Castleman Eye Center. We are committed to providing you with excellent service in every area including billing and insurance claims filing. Please read and sign our Financial Policy below:

Our practice participates in many Vision and Medical insurance plans. If your plan does not cover services provided by our physicians, payment in full is expected at the time of your visit. We accept cash, checks, VISA, MasterCard, and Discover.

Please be sure to provide us with your most current insurance card(s) at each visit.

We cannot properly file your insurance claim if we do not have accurate insurance information in your account. If you do not have your insurance card with you we will be happy to see you but payment in full will be due at the time of service. You must bring your insurance card to us in order for the claim to be filed. Once payment has been received from the insurance company, we will gladly refund the patient payment less any applicable co-pays or deductibles.

All payments are required at the time services are rendered. If, for some reason you are not prepared and need us to bill you, there is an additional $10 billing fee. We do offer financing through Care Credit and accept VISA, Mastercard, American Express and Discover. ALL DEDUCTIBLES ARE COLLECTED PRIOR TO SURGERY AND/OR AT TIME OF SERVICE.

Eye Examinations have two portions, the eye exam and the refraction. The refraction is the measurement taken to determine if there is a need for glasses and if so, your glasses prescription. Refractions may be done for routine eye exams or medical exams. **Most insurance plans, including Medicare do not pay for refractions. You will be asked to pay for the refraction at the time of your visit.**

During the course of your exam, the doctor may order special diagnostic tests that are not included in the exam fee. These tests will be billed to your medical insurance and you will be responsible for paying any deductible/copay in advance. We will do our best to estimate what your cost will be. However, if the amount is not correct based on the response from your insurance company, we will either bill you the difference or refund the overpayment.

Many insurance plans require a referral/authorization for office visits. You will need to obtain this referral/authorization from your primary care physician **prior** to being seen in our office. If you are having surgery we will assist in getting pre-certification or prior approval for your procedure. Please keep in mind that most insurance plans have deductibles, co-payments, or both, associated with surgery, and you will be responsible for payment of these fees prior to surgery. **Please note, if you are scheduled for surgery there will be 3 separate fees/claims filed. One the surgeon, one for anesthesia and another for the operating room/facility. You may contact the hospital or surgery center for specific information regarding their fees. We suggest that you review your insurance plan prior to visiting our office, so you will be familiar with your insurance plan guidelines and requirements.**

Thank you, and let us know if we can be of further assistance.

I certify that the information given by me in applying for payment under my insurance contract is correct. **I authorize any holder of my personal information, whether medical or otherwise, to release to any third party payers (including Medicare, Medicaid, and other parties) information needed to process claims for health care benefits.** I request that payment of authorized health care benefits be paid and I assign the benefits payable for physician services to the physician or organization furnishing the services. I authorize such physician or organization to submit a claim to my health insurance carrier or any other third party payer including Medicare and Medicaid on my behalf. I request payment of benefits under Title XVIII (Medicare) and XIX (Medicaid) of the Social Security Act, to **Castleman Eye Center**. I understand that I am financially responsible for charges not covered by the insurance company, and I hereby guarantee timely payment in full of any such charges.

By signing below, you are acknowledging that you have read and fully understand our Financial Policy.

Patient Signature (or Legal Guardian): _____ Date: _____

U:workgroups:forms

Notice of Privacy Practices and Patient Consent
For Use and Disclosure of Protected Health Information

_____ _____

PATIENT NAME **DATE**

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

I understand that Castleman Eye Center may use or disclose my protected health information for treatment, payment or health care operations—which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Castleman Eye Center has a detailed document called the *'**Notice of Privacy Practices**'*. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the *'Notice'* before signing this agreement. If I ask, Castleman Eye Center will provide me with the most current *Notice of Privacy Practices*.

My signature below indicates that I have been given the chance to review such copy of the *Notice of Privacy Practices*. My signature means that I agree to allow Castleman Eye Center to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Castleman Eye Center has taken action relying on this consent.

_____ _____

SIGNATURE (Patient or Legal Custodian/Authorized Representative) **DATE**

_____ _____

Relationship to Patient if signed by another party **DATE**

I give my permission for information to be released to the following: (Optional)

Name: Relationship:

Name: Relationship:

You may obtain a copy of our *Notice of Privacy Practices*, including any revisions of our *'Notice'* at any time by contacting: Castleman Eye Center 734-283-0500 or asking at our Registration Desk.

FORM Us

REFRACTION FEE FORM

Patient Name: _____

A refraction is the process of measuring your eyes. The results of this test may also be used to determine if you have a medical diagnosis for decreased vision or if glasses are needed.

It is an essential part of a complete eye examination. There are some eye conditions which require the doctor to make the refraction measurements, even if you don't end up changing your eyeglasses.

How is the refraction paid and who pays for it?

- Some medical insurance plans will pay for you to be refracted, although **most** medical insurance plans, (including Medicare) **do not**. The $~~3~~4 refraction fee is collected from you at the end of your visit (in addition to any co-payment that your insurance plan may require).

- This is a once a year fee to the patient, even if the refraction is performed more than once per year.

- Some patients have a separate "Vision Plan" insurance that pay for refractions and periodic "routine eye exams". These plans can't be used if your visit is for any medical eye condition (glaucoma, cataract, dry eyes, macular degeneration, diabetes, etc…)

Patient Signature: _____

Date: _____