



Snigdha Singh, M.D.
Zachary D. Pearce, D.O.

James R. Valice 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, co-pays and deductibles 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.

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 Rd. #100
Troy, MI 48083
Tel: (248) 813-0099
Fax: (248) 813-0210

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

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		Ethnicity: Hispanic Not Hispanic	
Asian Black or African American		Language Preference: English Other	
Native Hawaiian or Other Pacific Islander			

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?			
Insurance	Location	Patient/Family	Google Internet Optometrist
		Family Doctor	Other

If Referred by Doctor please complete:

NAME: _____

ADDRESS: _____

PHONE: _____

Medical History Questionnaire

Patient Name: _____

Date of Birth: _____

Allergies (drug, food or substance) & Reaction Severity

_____ mild / moderate / severe
_____ mild / moderate / severe

Past Ocular History: (Please mark all that apply)

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> No History of Eye Disease | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Hyperopia (Far sighted) | <input type="checkbox"/> Myopia (Near sighted) |
| <input type="checkbox"/> Amblyopia (Lazy eye) | <input type="checkbox"/> Diabetic Retinopathy | <input type="checkbox"/> Iritis | <input type="checkbox"/> Optic Neuritis |
| <input type="checkbox"/> Aphakia | <input type="checkbox"/> Dry Eyes | <input type="checkbox"/> Keratoconus | <input type="checkbox"/> Retinal Detachment |
| <input type="checkbox"/> Astigmatism | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Macular Degeneration | |

Other _____

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

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> No Prior Eye Surgery | <input type="checkbox"/> Foreign Body Removal | <input type="checkbox"/> Glaucoma laser surgery | <input type="checkbox"/> Trabeculectomy |
| <input type="checkbox"/> Blepharoplasty | <input type="checkbox"/> Retinal Laser Surgery | <input type="checkbox"/> Punctal Plugs | (Glaucoma surgery) |
| <input type="checkbox"/> Cataract Surgery _____ | <input type="checkbox"/> LASIK _____ | <input type="checkbox"/> RK | <input type="checkbox"/> Vitrectomy/Retina Surgery |
| <input type="checkbox"/> Corneal Transplant _____ | <input type="checkbox"/> PRK | <input type="checkbox"/> Strabismus Surgery
(eye muscle surgery) | |

Other _____

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

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

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

Insulin? Yes _____ No _____

Plaquenil for Rheumatoid Arthritis? Yes _____ No _____

Other _____

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

Current Medications: (Please list)

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

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

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):

<p>Eyes</p> <ul style="list-style-type: none"> <input type="checkbox"/> Previous Surgery <input type="checkbox"/> Contact Lens <input type="checkbox"/> Pain <input type="checkbox"/> Double Vision <input type="checkbox"/> Glaucoma <input type="checkbox"/> Cataracts <input type="checkbox"/> Macular Degeneration <input type="checkbox"/> Dry Eyes <input type="checkbox"/> Flashes <input type="checkbox"/> Floaters <p>Ear, Nose, and Throat</p> <ul style="list-style-type: none"> <input type="checkbox"/> Hard of Hearing <input type="checkbox"/> Ringing in Ears <input type="checkbox"/> Vertigo <p>Cardiovascular</p> <ul style="list-style-type: none"> <input type="checkbox"/> Chest Pain <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting Spells <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Irregular Heart Beat <input type="checkbox"/> Difficulty Lying Flat <p>Constitutional</p> <ul style="list-style-type: none"> <input type="checkbox"/> Fatigue / Weakness <input type="checkbox"/> Fever <input type="checkbox"/> Weight Gain / Loss 	<p>Respiratory</p> <ul style="list-style-type: none"> <input type="checkbox"/> Cough <input type="checkbox"/> Congestion <input type="checkbox"/> Wheezing <input type="checkbox"/> Asthma <p>Gastrointestinal</p> <ul style="list-style-type: none"> <input type="checkbox"/> Heartburn <input type="checkbox"/> Nausea / Vomiting <input type="checkbox"/> Jaundice / Hepatitis <p>Genito-Urinary</p> <ul style="list-style-type: none"> <input type="checkbox"/> Pain / Difficulty <input type="checkbox"/> Blood in Urine <input type="checkbox"/> History of Kidney Stones <input type="checkbox"/> History of STD's <p>Psychiatric</p> <ul style="list-style-type: none"> <input type="checkbox"/> Anxiety / Depression <input type="checkbox"/> Mood Swings <input type="checkbox"/> Difficulty Sleeping <p>Endocrine</p> <ul style="list-style-type: none"> <input type="checkbox"/> Increased Thirst <input type="checkbox"/> Increased Hunger <input type="checkbox"/> Increased Urination <input type="checkbox"/> Increased Sweating <input type="checkbox"/> Fingernail Changes 	<p>Blood / Lymphnodes</p> <ul style="list-style-type: none"> <input type="checkbox"/> Easy Bruising <input type="checkbox"/> Gums Bleed Easy <input type="checkbox"/> Prolonged Bleeding <input type="checkbox"/> Heavy Aspirin Use <p>MusculoSkeletal</p> <ul style="list-style-type: none"> <input type="checkbox"/> Stiffness <input type="checkbox"/> Arthritis <input type="checkbox"/> Joint Pain / Swelling <p>Skin</p> <ul style="list-style-type: none"> <input type="checkbox"/> Rash / Sores <input type="checkbox"/> Lesions <input type="checkbox"/> Hives / Eczema <p>Neurological</p> <ul style="list-style-type: none"> <input type="checkbox"/> Seizures <input type="checkbox"/> Weakness / Paralysis <input type="checkbox"/> Numbness <input type="checkbox"/> Tremors <p>Immunologic</p> <ul style="list-style-type: none"> <input type="checkbox"/> Hives <input type="checkbox"/> Itching <input type="checkbox"/> Runny Nose <input type="checkbox"/> Sinus Pressure
---	--	---

Dry Eye Survey

- _____ **Fluctuation in vision** _____ **Redness** _____ **Film over vision** _____ **Burning**
- _____ **Tired Eyes** _____ **Watery Eyes** _____ **Feeling of sand or grit in eye(s)**

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: _____

Refraction Fee with Optomap

Patient Name: _____

Date: _____

A refraction is the process of measuring your eyes for glasses. 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 us to perform the refraction measurements, even if you don't end up changing your eyeglasses. The purpose of the refraction can be to assist the doctor in diagnosing your eye condition.

How is the refraction paid and who pays for it?

- Some medical insurance plans will pay for the refraction, although **most** medical insurance plans, (including Medicare) **do not**. The \$45 refraction fee is collected from the patient.
- 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...)
- This fee also includes a technologically advanced retina scan of both eyes, known as the **Optomap**. This new technology allows us to scan and see areas inside the eye that otherwise cannot be seen during the exam by the doctor. This allows the doctor look for diseases & monitor the health of your eyes in ways that were never possible before now. This is a screening test, not covered by your insurance.

Patient Signature:

Castleman Eye Center

Patient Web Portal Instructions

You now have access to your medical record on line. To Register, go to:

Our website, www.castlemaneyecenter.com and Click on Patient Portal at the top right of home page or Go to: www.myeyecarerecords.com

- Click the Registration Link
- Your name must be entered exactly how it appears in our system along with your social security number.
- Your initial Password is 1234. The portal will prompt you to change this.

You can also send your doctor a message via the web portal. Questions will be answered within 48 hours.

If you have any questions, call: 734-283-0500

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.

By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due, lab results, or any other healthcare related function. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information (PHI) regarding my healthcare events. I consent to the receiving multiple messages per day from my healthcare provider, when necessary. I consent to allowing detailed messages on my voice mail, answering system, or with another individual, if I am unavailable at the number provided by me.

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.

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: _____

FORM Us