Robert C. Erickson, M.D Timothy P. Page, M.D. Maria Jancevski, M.D.

OAKLAND
OPHTHALMIC
SURGERY, P.C.

Patient Information:

Patient Name (Last, First, MI):_____

Birthdate:_____ Social Security #:_____ Gender: __M __F

Home Address:_____City_____State_____Zip_____

Home #:_____ Work #:_____

Cell #:_____ ER contact Name & phone #:_____

E-mail:_____

Marital Status: Single Married Widow Divorced

Primary Care Physician _____ Office Phone: _____

Referring Physician_____ Office Phone: _____

Meaningful use information:
Primary Language_____ Race_____ Ethnicity_____

If patient is a minor:
Guardian Name:_____ Birthdate_____ Social Security # (last 4) _____

Signature_____**Date**_____

E-prescribing allows physicians and other medical practitioners to write and send prescriptions to a participating pharmacy electronically, through a secure internet connection, instead of using handwritten or faxed notes or calling in prescriptions. Please provide your pharmacy information below.

PHARMACY Name: _____

CITY Pharmacy is in: _____

PHARMACY Phone Number:_____

PHARMACY Crossroads: _____

Health and Social History

Patient Name_____ Birth date_____

Do you have or have you had any of the following? (please check)

- □ Acid Reflux
- □ Allergies
- □ Alzheimer's/Dementia
- □ Anemia
- □ Anxiety
- □ Arthritis
- □ Asthma
- □ Auto Immune Disease
- □ Breathing Problems
- □ Bleeding Tendencies
- □ Cancer _____
- □ Carotid Artery Disease
- □ Colitis
- □ Crohn's
- □ Depression
- □ Diabetes- Type 1__Type 2__
- □ Emphysema
- □ Enlarged Prostate
- □ Heart Attack
- □ Heart Condition
- □ Hepatitis
- □ Herpes S Virus
- □ High Blood Pressure
- □ High Cholesterol
- □ Irregular Heartbeat
- □ Kidney Disease
- □ Liver Disease
- □ Lupus
- □ MRSA
- □ Multiple Sclerosis (MS)
- □ Myasthenia Gravis
- □ Migraines
- □ Parkinson's
- □ Rheumatoid Arthritis
- □ Rosacea
- □ Sarcoid
- □ Seizures
- □ Shingles
- □ Sinus
- □ Sjogren's
- □ Stroke
- □ Thyroid Hyper/Hypo
- □ Tuberculosis
- □ Wegner's
- □ Other_____

Have you had any past eye Surgery/ Trauma: Please List:
Right Eye: _____ Left Eye: _____

Surgeries/ hospitalizations within the last 5 years: _____

Social History:
Tobacco use: Current Smoker_____ Former Smoker _____ Never Smoked_____
Alcohol use: Current Drinker_____ Former Drinker _____Never Drinker_____
Average drinks number of drinks: _____ per _____ (day, week or month)

Do you currently drive a Car? Yes_____ No_____
Do you live alone? Yes_____ No_____

Family History (Immediate Family)

DISEASE/CONDITION	NO	YES	RELATIONSHIP TO YOU
Cataract			
Diabetes			
Glaucoma			
Macular Degeneration			

Primary Care Physician_____ **Phone**_____
Endocrinologist_____ **Phone**_____
Rheumatologist_____ **Phone**_____

Today's Date_____

MEDICATIONS/ ALLERGIES

Patient Name_____ Birth date_____

Please list all current Medications, Vitamins or Supplements. If you have a list we can make a copy. If you are unsure of the name of Medication please list what type of Medication you are taking and what condition you are taking it for.

MEDICATION	DOSE	TIMES PER DAY	WHAT IS THE MEDICATION USED FOR

Please List All Allergies ☐ None

ALLERGIES	REACTION	ALLERGIES	REACTION

Today' s Date_____

Oakland Ophthalmic Surgery

MEDICAL & VISION EXAMS • REFRACTIONS • PRESCRIPTION RELEASE

The type of care you need will determine if medical or vision insurance is billed

- Medical insurance covers medical eye exams relating to any health issues affecting your eyes.
- Vision insurance covers routine eye exams specific to how your eyes see with glasses and/or contact lenses.

I understand that my medical coverage must be billed if my visit relates to the discovery or treatment of an eye disease, injury, or other issues that are outside the scope of a routine eye exam.

We will check your insurance benefit eligibility and make every attempt to help you understand and make the most of your benefits. It is important to understand that things can change between the eligibility check and the actual payment of the claim. For example, changes in insurance, lapse of time, new benefit years, claims that arrive to the payer after eligibility was checked, and purchases made between checking eligibility and placing an order for glasses or contacts. A quote of benefits is not a guarantee of benefits or payment. **Charges not covered by your insurance company or benefit plan as well as co-payments, deductibles, and co-insurance amounts, are your responsibility**

If you have questions, please call our billing department direct at 248-644-7119.

What is a refraction? "Which is better 1 or 2?" The refraction is the test done by your eye doctor to determine if corrective lenses will help you see better. Most medical insurances consider this a non-covered benefit. If your insurance company does not cover your refraction, you will be asked to pay a fee of $55.

I understand that a contact lens fitting is required in addition to my complete visi on exam to determine my contact lens prescription. This fitting involves a management fee, ranging from $55 to $300, depending on the complexity of the fit. I also understand that the contact lens fitting process may take more than one visit. I further understand that the finalization of the contact lens fitting process often involves verbal acknowledgement of successful wear, and I may provide this acknowledgement over the phone

I understand that my eye doctor is required by the Federal Trade Commission to provide me with a copy of my prescription at the conclusion of my exam or contact lens fitting process, whether or not I desire it or ask for it.

Once a final prescription has been determined, I will receive a copy of my prescription either hard copy or via email. If I elect to receive my prescription hard copy, I understand that this may involve an additional visit to the office if my prescription is finalized over the phone.

Please check the following ways in which you prefer to receive copies of your prescriptions:

☐ Hard Copy

☐ Email _____(please provide email address)

Patient or Guarantor signature_____ Date_____

For patients who are minors, signature of parent or legal guardian

OAKLAND OPHTHALMIC SURGERY, P.C.

Consent to Treat • Consent to Communications • HIPAA • Patient Financial Responsibility • Assignment of Benefits

Patient Name (Please print) _____ Date of Birth (MM/DD/YYYY) _____

Thank you for trusting us with your eye care needs. Our team is committed to providing you with expert, compassionate medical and vision care. Please read through this document, ask us any questions you may have, and sign at the bottom. Please understand that payment of your bills is considered part of your treatment. We are happy to provide you with a copy of this document upon request.

General Consent to Care I, the undersigned, for myself, a minor child, or another person for whom I have authority to sign, hereby consent to medical and vision care and treatment, as ordered by a provider, which such medical or vision care and treatment is provided through my provider's practice, which is part of the Oakland Ophthalmic Surgery network (the "Practice"). This consent includes my consent for all medical and vision services rendered under the general or specific instructions of the provider. I agree and acknowledge that Oakland Ophthalmic Surgery is not liable for the actions or omissions of, or the instructions given by the provider(s) who treat me while I am a patient. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me as to the result of treatments or examinations.

I understand that I have the right to discuss the treatment plan with my physician about the purpose, potential risks, and benefits of any tests ordered for me. If I have concerns regarding any test or treatment recommended by my provider, I understand that am encouraged to ask questions.

HIPAA Privacy Policy I acknowledge that the Practice has made available to me the "Notice of Privacy Practices" in compliance with current HIPAA regulations.

Consent to Call, Email & Text By signing below I agree and authorize Oakland Ophthalmic Surgery (and entities or individuals working on Oakland Ophthalmic Surgery behalf) to deliver or cause to be delivered calls, text messages, and/ or emails using an automatic telephone dialing system or an artificial or prerecorded voice at the numbers(s) and /or email address(s) I have provided to schedule an appointment, remind me I am due for an appointment, remind me of an upcoming appointment, contact me that my eyewear or contact lenses are ready, contact me regarding outstanding payments or bills due, contact me about my account, and/or provide me messages containing advertisements or telemarketing. I understand that I may be charged by my phone provider or a third party provider for such communications and that I can revoke my consent at any time. I understand that I am not required to provide such an authorization as a condition of purchasing any property, goods or services from Oakland Ophthalmic Surgery.

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Insurance We participate with most insurance plans, including Medicare. If the undersigned or the patient for whom the undersigned has authority to sign is insured by a plan we accept but does not have an up-to-date insurance card, payment in full for each visit is required until coverage can be verified. A quote of benefits is not a guarantee of benefits or payment. Charges not covered by insurance company or benefit plan, as well as any co-payments, deductibles, and co-insurance amounts, are the undersigned's responsibility. If the undersigned has questions about what the applicable insurance or benefit plan will cover, please contact the insurance or benefit plan directly. Ultimately, it is the undersigned's responsibility to understand the applicable coverage. Therefore, we strongly encourage the undersigned to check with your insurance company regarding coverage prior to any office visit or procedure.

Referrals Some insurance plans require the patient to obtain a referral for services. Please review your insurance policy to see if a referral is required prior to the office visit. If a required referral is not on file at the time of the visit, the appointment could be rescheduled or the patient will be responsible for all charges incurred on this date.

Assignment of Benefits I request that payment of authorized insurance benefits for Medicare, Medicaid, and other health insurance and vision benefit plans be paid directly to the Practice for all medical, vision, surgical, medication, diagnostic testing, laboratory services, supplies, and equipment provided to me during all courses of treatment and care provided by the Practice. I also understand and agree this Assignment of Benefits will continue for as long as I am being treated or cared for by the Practice and will constitute a continuing authorization, maintained on file, which will authorize and allow for direct payment to the organization of all applicable and eligible coverage benefits for all subsequent and continuing treatment, services, supplies, and/or care provided. I also realize that I am responsible for paying any non-covered services, co-payments, deductibles, or co-insurance amounts due.

Patient Financial Responsibility I understand that I am financially responsible to the Practice for any charges not covered by health care or vision plan benefits. It is my responsibility to notify the Practice of any changes in my health care or vision 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 as determined by the Practice and/or my health care insurer or vision benefit plan if the submitted claims or any part of them are denied for payment. All copays and non-covered services are expected to be paid at the time of service. In some cases, deductibles and co-insurance will be collected prior to service.

I understand that by signing this form, I am accepting financial responsibility as explained above for payment for all services and products received.

This consent and authorization will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services. I certify that I have read and understand the above statements.

Patient/Legal Representative Signature _____ Date _____

OAKLAND OPHTHALMIC SURGERY, P.C.

Authorization to Disclose Information to Those Involved in My Care

I authorize Oakland Ophthalmic Surgery to disclose or provide my Protected Health Information including, but not limited to:

- Health and Billing Information
- Appointment times & Dates
- Information regarding behavioral and mental health services, substance use disorder treatments, and communicable diseases such as sexually transmitted diseases and human immunodeficiency virus (HIV infection, Acquired Immune Deficiency Syndrome or AIDS related complex) may be shared unless written exclusion is on file.

I understand the person(s) I list to Authorize to Disclose Information to those Involved in my Care, will also be listed as my emergency contact. If this information is to change, the front desk will need to be notified.

To the following people: (please print full name)

Name:_____

Relationship: _____Phone number:_____

Name:_____

Relationship: _____Phone number:_____

Name:_____

Relationship: _____Phone number:_____

Is there any protected health information you would like to exclude from disclosure to the parties listed above? If yes, fill in here:_____

This authorization has No Expiration unless revoked or terminated—in writing—by the patient or patient's personal representative.

_____ _____

Patient/Legal Representative Signature Date

This form replaces all prior disclosure authorizations as of the date above.

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Consent to Obtain Patient Medication History

Patient medication history is a list of prescriptions that healthcare providers have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history.

I give my permission to allow my healthcare provider to obtain by medication history from my pharmacy, my health plans, and my other healthcare providers.

By signing this consent form you are giving your healthcare provider permission to collect and share your pharmacy and your health insurer information about your prescription that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health issues such as depression.

Patient/Legal Representative Signature

Date