children's
EYE CARE

PEDIATRIC OPHTHALMOLOGY + ADULT STRABISMUS

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Welcome!

We would like to thank you for choosing our office for your eye care needs. This information is to assist you with any questions and help you prepare for your visit with us.

Please fill out the enclosed forms and bring them with you to your appointment. Also, please bring your insurance card(s), driver's license or identification, glasses, contact lenses and any necessary insurance referrals.

If a parent or legal guardian will not be attending the appointment, it's required that you send a note stating that name of the person who will be bringing your child and that it's OK for us to instill dilating drops. The person bringing your child will be required to present us with a Driver's License or State ID to prove his/her identity. We also need to have a number to reach you (the parent or legal guardian) at during the exam. Please note we have to refuse examination or treatment if we have any concerns with who is accompanying the child to the appointment.

WHAT TO EXPECT AT YOUR FIRST VISIT

Your exam will begin with a certified ophthalmic assistant. She/he will perform a history and visual acuity, confrontational visual fields, extra ocular motility, pupil assessment and muscle balance. If there are motility (strabismus) issues, either a certified orthoptist or the doctor will see the patient prior to dilation. None of these tests will hurt or surprise the child. After that, drops will be instilled to dilate the pupils. It usually takes approximately 30 – 45 minutes for the drops to work. This is done so that the doctor can see details about the back of the eye and also the need for glasses can be determined.

The initial appointment will last approximately 2 hours and will include dilation. Dilation typically lasts about 12-24 hours. The patient may be light sensitive and have some difficulty seeing small details up close (usually within arms distance). However, some people have difficulty seeing at farther distances and have difficulty driving. *Please note, with the exception of some adults with strabismus, it's necessary to perform a dilated eye exam on the initial visit. Otherwise, the doctor will not have all of the details necessary to provide advice or treatment suggestions.

Again, thank you for choosing our office. We look forward to meeting you. If you have any questions prior to the visit, please feel free to call us or visit our website at www.childrenseyecaremich.com.

BRING TO YOUR FIRST APPOINTMENT

Cash, check or credit card (MasterCard, Visa or Discover) to pay for any services not covered by your insurance company.
All medical and vision insurance cards (even if we don't participate), driver's license or state identification.
Medical History, Authorization to Release HPI, Medical vs Vision forms.
If applicable: Glasses, contact lenses, contact lens box and/or name.
If your insurance company requires authorizations from your primary doctor, remember every visit needs prior approval.
If a patient is a minor, parent or legal guardian must be present at initial visit. A waiver can be signed for subsequent visits.

YOU AND YOUR INSURANCE

CO-PAYS AND DEDUCTIBLES
Our contract with your insurance company requires that we collect any known co-pays and/or deductibles. We are in violation of our contract if we don't collect these fees. We will be collecting these fees at your visit. Please be prepared to pay at this time.

PAYMENT OPTIONS
We accept cash, check and major credit cards (MasterCard, Visa and Discover).

REFRACTIONS
Some insurance companies may not pay for refractions to determine if the patient needs glasses or has a refractive disorder (or pathology). Therefore, it could be an out-of-pocket cost to patients. We will attempt to bill your insurance plans for this test. Our fee is $30.00.

INSURANCE REFERRALS
If your insurance company requires that you obtain referrals or authorizations from your primary care physician (i.e. family doctor, internist), **please request the referral prior to your visit.** You may need to pick the referral up from their office - check with your primary care physician. Also, please remember you will need a referral for every visit.

MEDICAL vs VISION INSURANCE
Our ophthalmologists are medical doctors and will be providing you with a very comprehensive, medical eye exam. Your vision insurance is intended to provide you with a baseline eye evaluation. If you are being evaluated for medical reasons (strabismus, amblyopia, blocked tear ducts, infections, etc) you are being provided with medical care. Your vision company doesn't provide coverage for medical care. Therefore, we will be billing your medical insurance for visits related to medical complaints and problems.

If you are scheduled to see our optometrist, we will bill the appropriate plan for what the patient is being seen for. If it's a medical problem, it will be billed to the medical insurance. If it's a routine exam, it can be billed the vision carrier (if we participate with the plan).

CONTACT LENS EVALUATIONS
Many people question why there's an additional fee for the contact lens evaluation. The reason is because contact lens patients require many additional tests and monitoring over and above what is done during a routine eye exam. Contact lenses are medical devices and even though they may feel fine, there are health risks that must be taken seriously. A few of the procedures that are part of a contact lens evaluation: determining your contact lens prescription (contact lens over-refraction), measuring the shape and power of your cornea (keratometry), assessment of the contact lens fit on your eye and detailed slit-lamp microscope exam to check the health of the eye from contact lens wear.

INSURANCE PLANS WE PARTICIPATE WITH
AARP, ABS, ACO-Oakwood, Aetna, Alliance, BCBS, BEHP, Blue Care Network, Blue Community Choice, Children's Special Health Services (CSHCS), Cigna, Cofinity, Coventry, Coventry-Mi Child, DMC, HAP, Health Plus, Humana, Great West Health Plan, Golden Rule, Heritage Vision, MDWHP AKM/Wayne Choice, McLaren Health Plan, McLaren Health Commerical, MEBS, Medicaid, Medicare BCBS Advantage, Medicare Advantage Meridian, Midwest Health Plan, Molina, Molina MI-Child, NGS, NGS-Oakwood, PHCS/Multiplan, Priority Health, RR Medicare, Spectera Vision, St John Smart Plan (Tier-2), Teamsters, Total Health Care Commercial, Total Health Care Medicaid, Total Health Care MI-Child, Tricare Prime, Tricare Standard, United Health Care and UHCCP.

Please note that not all of our doctors participate with every plan mentioned above. We will do our best to schedule you with a participating doctor. However, we can't guarantee that if you're coming to see us for an emergency visit for a vision threatening issue. If you don't see your carrier on this list, you should contact your carrier to verify your benefits and their referral network.

AUTHORIZATION TO RELEASE HEALTH INFORMATION

To make it easier to discuss medical care about your child, or you, with those that help you with care of the patient, we ask that you complete this form.

I AUTHORIZE: Children's Eye Care

TO RELEASE, AS NEEDED, MY PROTECTED HEALTH INFORMATION TO:

PERSON'S NAME:_____ RELATIONSHIP:_____ PHONE #:_____

PERSON'S NAME:_____ RELATIONSHIP:_____ PHONE #:_____

PERSON'S NAME:_____ RELATIONSHIP:_____ PHONE #:_____

PERSON'S NAME:_____ RELATIONSHIP:_____ PHONE #:_____

PERSON'S NAME:_____ RELATIONSHIP:_____ PHONE #:_____

By my signature, I authorize that my protected health information (also known as PHI) may be used or disclosed with the above-mentioned people. I understand that I have the right to be aware of all PHI that will be disclosed to these people. I understand that Children's Eye Care will not condition any aspect of my treatment or payment I understand that I am under no obligation to sign this Authorization. I understand that this Authorization may be revoked in writing at any time by my signing the revocation section below and returning it to Children's Eye Care unless: they have previously acted in reliance on this Authorization. By my signing the Authorization, I acknowledge that I have read and understand this Authorization. Further, I give my authorization to Children's Eye Care to use or disclose PHI in accordance to the terms of the Authorization.

PATIENT/PARENT/GUARDIAN'S SIGNATURE: _____ DATE:_____

PATIENT'S NAME (PRINTED): _____

SOCIAL SECURITY #: _____ DATE OF BIRTH:_____

Privacy Protection

We are dedicated to protecting the privacy of our patient's information. We will not give any information to any person without written permission from the patient. We will also ask that the following question be answered before receiving records. If you wish to not answer this question, we will ask that you provide us with an official picture I.D. (i.e. driver's license, state ID, military ID, etc).

What is the maiden name of patient's mother:_____

MEDICAL vs VISION INSURANCE

Do you have vision/optical coverage? □ Yes □ No

One of the most challenging billing issues in an ophthalmology office has to due with if we should be billing the medical or vision plan.

An ophthalmologist is a medical doctor (just like your family doctor or cardiologist) and provides very comprehensive, medical eye exams. In our practice, none of our ophthalmologists participate with vision plans. However, our optometrist participates with a few.

For Patients with both Medical and Vision Coverage

Your vision insurance is intended to provide you with a baseline eye evaluation. If you are being evaluated for medical reasons you are being provided with medical care. Your vision company doesn't provide coverage for medical care. Therefore, we will be billing your medical insurance for visits related to systemic issues related to the eye or medical eye complaints and problems.

For Patients with no Vision/Optical Coverage Seeing our Optometrist

If you are being seen for a routine eye evaluation and don't have vision/optical coverage, your medical insurance will not pay for an eye exam. However, if you have a medical problem (corneal disorders, diabetes, "lazy eye," cataracts, glaucoma suspect, double vision, etc.), your visit is considered a medical problem and can be billed to your medical plan(s).

Also, please be aware that some plans have clauses in their policies about some eye problems and classify them as a non-payable. This isn't common but does exist. We will make every effort to appeal these types of rejections and educate your plans about ocular pathology and needed evaluation/treatment. However, we can't guarantee success in every scenario and you will be responsible for the bill if we can't obtain appropriate payment. Please remember that we didn't choose your plan for you and that's impossible for us to know every detail and clause in your plan.

I have read above and understand that none of the Ophthalmologist/Medical Doctors of Children's Eye Care participates with vision plans. I also recognize that if I have vision coverage and am seeing the Optometrist for a medical eye problem, my vision plan will not be billed. Instead, my medical plan will be billed. I also recognize that some insurance companies will not pay for an exam for every ocular diagnosis.

_____ _____

Signature Date

If the patient is new, how did you hear of us: **PATIENT REGISTRATION FORM FOR PEDIATRICS**

PATIENT'S LAST NAME	FIRST NAME	MIDDLE	GENDER	BIRTHDATE	SOCIAL SECURITY #

The Center of Medicare and Medicaid Services requires that we collect the patient's race, ethnicity and primary language.

RACE (choose one):
□ American Indian/Aleut
□ Asian
□ Black
□ Native Hawaiian/Pacific Islander
□ Other
□ Unknown
□ White
□ Spanish/Latin

ETHNICITY (choose one):
□ African
□ African American
□ Albanian
□ American
□ Asia
□ Asian Indian
□ Caucasian
□ Central American
□ Cuban
□ Ethiopian
□ European
□ Haitian
□ Hispanic, Latin
□ Iranian
□ Iraqi
□ Islander
□ Israeli
□ Latin American
□ Lebanese
□ Mexican
□ Middle Eastern
□ Native American
□ Nigerian
□ Other
□ Patient refused
□ Puerto Rican
□ South American
□ Unknown

LANGUAGE PREFERENCE (choose one):
□ African
□ Albanian
□ Arabic
□ Armenian
□ Bangla
□ Cambodian
□ Cantonese
□ Chinese
□ English
□ French
□ French Creole
□ German
□ Greek
□ Guajarati
□ Hebrew
□ Hindi
□ Hmong
□ Hungarian
□ Italian
□ Japanese
□ Korean
□ Laotian
□ Mandarin
□ Miao Hmong
□ Navajo
□ Persian
□ Polish
□ Portuguese
□ Romanian
□ Russian
□ Scandinavian
□ Serbo-Croatian
□ Spanish
□ Tagalog
□ Thai
□ Unknown
□ Urdu
□ Vietnamese
□ Yiddish

FULL STREET ADDRESS WHERE PATIENT LIVES	CITY, STATE AND ZIP WHERE PATIENT LIVES	WHO DOES PATIENT LIVE WITH? NAME

MOBILE # WHERE PATIENT LIVES	HOME # WHERE PATIENT LIVES	EMAIL ADDRESS	Would you like to communicate with the office via email?
( )	( )		☐ Yes ☐ No
Can you we send you appointment reminders via text message? ☐ Yes ☐ No	**OTHER PHONE NUMBER** ( )	**ALTERNATE PHONE LOCATION** □ WORK □ FAMILY/OTHER:_____	

FINANCIAL RESPONSIBILITY FOR DEPENDANT PATIENTS: PARENT/GUARDIAN INFORMATION

MOTHER/GUARDIAN'S LAST NAME	FIRST NAME	CHECK ONE	BIRTHDATE	SOCIAL SECURITY #
		□Biological Mother □Adopted Mother □Step-Mother □ Foster Mother □ Legal Guardian		

EMPLOYER'S NAME	EMPLOYER'S ADDRESS	EMPLOYER'S PHONE #

FATHER/GUARDIAN'S LAST NAME	FIRST NAME	CHECK ONE	BIRTHDATE	SOCIAL SECURITY #
		□Biological Father □Adopted Father □Step-Father □ Foster Father □ Legal Guardian		

EMPLOYER'S NAME	EMPLOYER'S ADDRESS	EMPLOYER'S PHONE #

PRIMARY DOCTOR OR PEDIATRICIAN'S NAME	ADDRESS/CITY/STATE/ZIP	PHONE NUMBER

REFERRING DOCTOR'S NAME (IF DIFFERENT)	ADDRESS/CITY/STATE/ZIP	PHONE NUMBER

ARE PARENTS? ☐ **Married** ☐ **Separated** ☐ **Divorced** ☐ **Single** ☐ **Widowed** ☐ **Both Deceased** ☐ **Legally removed from the child's life**

If the patient is a child not living with both parents, please also provide the address of the parent child doesn't live with:

NAME OF PARENT (child doesn't live with)	ADDRESS/CITY/STATE/ZIP	PHONE NUMBER

Medicare: I request that payment of authorized Medicare benefits be made on my behalf to Children's Eye Care (aka CEC) for services furnished me by CEC. I authorize any holder of medical information about me to relate to centers of Medicare and Medicaid services (formerly health care financing administration) and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information or insurer or agency shown. CEC accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and noncovered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier. **Medigap:** I understand that if a Medigap policy or other health insurance is indicated in item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to CEC, if possible or otherwise to me. **Other insurance:** I understand that CEC maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office and that CEC has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by CEC if I belong to a plan that does not appear on the above mentioned list. **Non-covered services:** I understand that CEC's contracts with health care service plans (i.e. HMOs, PPOs) relate only to items and services which are covered by the health care services plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care services plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with CEC to obtain necessary health care services plan authorizations.

Release of information: CEC may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to CEC for reimbursement for services rendered, and (2) any health care provider for continued patient care. CEC may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to state or federal law, statue or regulation. A copy of this authorization may be used in place of the original.

Financial Agreement: I agree that in return for the services provided to the patient by CEC, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to CEC for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to CEC. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to CEC. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill. Also, I agree to reimburse CEC the fees of any collection agency , which may be based on a percentage at a maximum of 32% of the debt, and all costs, and expenses, including reasonable attorneys' fees, we incur in such collection efforts.

Signature_____ Date_____