Michigan Eye Consultants

Health Screening Questionnaire

Michigan Eye Consultants is committed to your safety. The MEC staff is sanitizing the office regularly and screening all patients for COVID-19 symptoms prior to their appointments and when the patient arrives.

Please answer the following questions:

Have you had a fever in the last 48 hours or temperature greater than 99.5 F?
Yes / No

Have you been in direct contact with anyone with a confirmed case of COVID-19 in the last 14 days?
Yes / No

If you have had COVID-19 and recovered, have you had at least 2 negative tests and self-isolated for at least 14 days afterwards?
Yes / No / N/A

Have you had in the last 14 days, or are you currently experiencing, any of the following symptoms (check all applicable symptoms below):
Yes / No

◯Cough ◯Headache ◯ Shortness of Breath ◯ Fever

◯New Loss of Taste or Smell ◯ Sore Throat

◯ Persistent Pressure / Pain in the Chest ◯ Chills ◯ New Confusion

◯Muscle Aches ◯ Abdominal Pain ◯ Fatigue

In compliance with government requirements and recommendations, you are advised to:

1. Wear mask or face covering in the office
2. Wash your hands with soap and water for at least 20 seconds OR
3. Clean your hands with alcohol-based hand sanitizer

_____ _____ _____

Signature of patient/representative Name (Pt/Rep) Date

Michigan Eye Consultants

Optomap and Wellness OCT

Vision threatening diseases such as glaucoma, macular degeneration, diabetes, or changes from high blood pressure or cholesterol have no signs or symptoms, so our practice is using state-of-the-art technologies to assess the health of your eyes. Our Doctors can detect vision threatening and systemic diseases in their very early stages when they are most treatable.

Optomap: An integral part of your eye health examination, because OPTOMAP provides a revolutionary 200-degree high definition wide view image of the inside of your eyes without eye dilation. **The cost is $30.**

Wellness OCT (Optical Coherence Tomography): The Wellness OCT allows the Doctors to view the layers of the retina below the surface image captured by the Optomap. **The cost is $30.**

The Doctors highly encourage you to have **BOTH** tests as part of your annual eye health examination today. **The discounted cost of both tests is $50.**

Yes, I accept the fee and would like to have:

_____ Optomap & Wellness OCT

_____ Wellness OCT

_____ Optomap

_____ _____ _____

Signature of patient/representative Name (Pt/Rep) Date

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I am currently experiencing or being treated for the following condition(s):

CONSTITUTIONAL		**EARS, NOSE AND THROAT**	
Fever	YES	Allergies / Hay Fever	YES
Weight Gain / Loss	YES	Sinus Congestion	YES
		Dry Throat / Mouth	YES
SKIN ISSUES	YES	Hearing Aids	YES
		Deafness	YES
NEUROLOGICAL			
Headaches	YES	**VASCULAR / CARDIOVASCULAR**	
Migraines	YES	Diabetes	YES
Seizure	YES	Heart Disease	YES
		High Blood Pressure	YES
EYES		High Cholesterol	YES
Loss of Vision	YES		
Blurred Vision	YES	**GASTROINTESTINAL**	
Distorted Vision / Halos	YES	Diarrhea	YES
Double Vision	YES	Constipation	YES
Dryness	YES		
Mucus Discharge	YES	**GENITOURINARY**	
Redness	YES	Gonads / Kidney / Bladder	YES
Itching	YES		
Burning	YES	**BONES / JOINTS / MUSCLE**	
Excess Tearing	YES	Rheumatoid Arthritis	YES
Glare/Light Sensitivity	YES	Muscle Pain	YES
Chronic Infection of Eye(s)	YES	Joint Pain	YES
Styes / Chalazion	YES		
Flashes	YES	**LYMPHATIC / HEMATOLOGICAL**	
Floaters	YES	Anemia	YES
Color Blind	YES	Bleeding Problems	YES

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RESPIRATORY		**ENDOCRINE**	
Asthma	YES	Thyroid / Other Glands	YES
Emphysema	YES		
Sleep Apnea	YES	**ALLERGIC / IMMUNOLOGIC**	YES
FAMILY HISTORY			
Blindness	YES	Diabetes	YES
Cataracts	YES	Heart Disease	YES
Glaucoma	YES	High Blood Pressure	YES
Crossed Eyes	YES	High Cholesterol	YES
Macular Degeneration	YES	Kidney Disease	YES
Retinal Problems	YES	Lupus	YES
Arthritis	YES	Thyroid	YES
Cancer	YES		

List any medication you are taking (including oral contraceptives, aspirin, over the counter meds and home remedies). You can also have our eyecare team make a copy of your medication list.

_____

Do you have any allergies to medication or the environment?

_____

List all major injuries, surgeries, and hospitalizations you have had:

_____

Are you pregnant? Yes / No

Any present / previous gestational diabetic issues? Yes / No

Do you use tobacco? Yes / No

Do you use non-prescription drugs? Yes/No

Would you like your Doctor to evaluate you for contact lenses today? Yes / No

Rate how your contact lenses feel **immediately** after you put them in: Poor / Average / Excellent

Rate how your contact lenses feel **just before** you take them out: Poor / Average / Excellent

_____ _____ _____

Signature of patient/representative Name (Pt/Rep) Date

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Patient's name: _____ DOB: _____ Gender: M / F / NA

Address: _____ City: _____ Zip: _____

Cell phone: ( ) _____ Email: _____

Person(s) authorized to access my health information (name/relationship):

_____

Primary Care Physician: _____ Phone: ( ) _____

Medical Insurance:

Insurance Name: _____ Subscriber ID: _____

Insured Name: _____ Insured DOB: _____ Relationship to pt: _____

Name of Secondary / Medigap Insurance: _____

Vision Insurance:

Insurance Name: _____ Subscriber ID: _____

Insured Name: _____ Insured DOB: _____ Relationship to pt: _____

Payment Authorization

Thank you for choosing Michigan Eye Consultants as your eyecare provider. We are committed to providing you with the highest quality of eye care. We ask that you read and sign the following to acknowledge your understanding of our patient financial policies.

○ The patient (or patient's guardian, if a minor) is ultimately responsible for the payment of treatment and care ○ We will bill your insurance for you. The patient is required to provide the most correct and updated insurance information ○ The patient is responsible for payment of co-pay, co-insurance, deductible and all other procedures or treatments not covered by your insurance plan

○ Co-pay is due on the day of service

○ Co-insurance, deductibles and non-covered items are due on the day of service

○ By my signature below, I hereby authorize the assignment of financial benefits directly to Michigan Eye Consultants and any associated healthcare entities for services rendered as allowable under standard third-party contracts. I understand that I am financially responsible for charges not covered by this assignment.

_____ _____ _____

Signature of patient/representative Name (Pt/Rep) Date

Receipt of Privacy Policy Notice & Contact Lens Prescription Release Notice

I, _____ (please print full legal name), the "Patient" or "Patient's legal representative" (if patient is a minor or an adult who is unable to sign this form), have been presented with the Notices of Privacy Policy AND the Contact Lens Prescription Release Policy, and have been offered a copy of such policy to keep for my records.

_____ _____ _____

Signature of patient/representative Name (Pt/Rep) Date

Michigan Eye Consultants

Privacy Policy

This Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information.

Use and Disclosures of Health Information

We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us.

Use and Disclosures Based on Your Authorization

Except as stated we will not use or disclose your health information without your written authorization. **Use**

and Disclosures Not Requiring Your Authorization

In the following circumstances, we may disclose your health information without your written authorization:

- To family members who are involved in your healthcare
- For purposes of public health and safety
- To Government agencies for purposes of audits and investigations
- To the FDA to report product defects or incidents
- When required by court orders, search warrants, subpoenas and as required by the law

Patient Rights

As our patient, you have the following rights:

- To have access to and/or a copy of your health information
- To receive an accounting of disclosures we have made of your health information ■ To request that we communicate with you in confidence
- To request that we amend your health information
- To receive notice of our privacy practices

Thank you for choosing Michigan Eye Consultants as your eyecare provider. We look forward to providing you with the best eye care in the market!

Contact Lens Prescription Release Policy

This Prescription Release Policy allows Michigan Eye Consultants to email the patient or the patient's representative an electronic copy of the finalized contact lens prescription, in compliance with the 2020 FTC amended ruling.

_____ _____ _____

Signature of patient/representative Name (Pt/Rep) Date