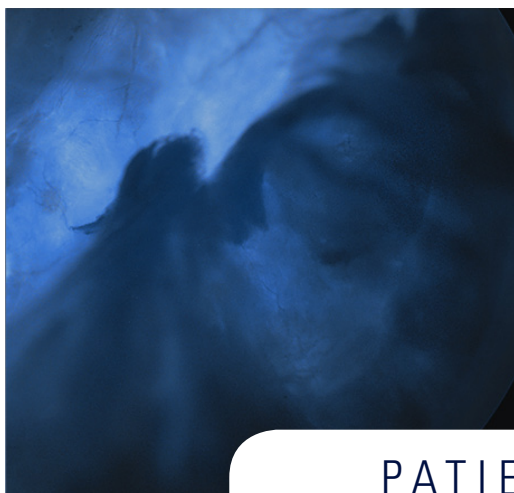
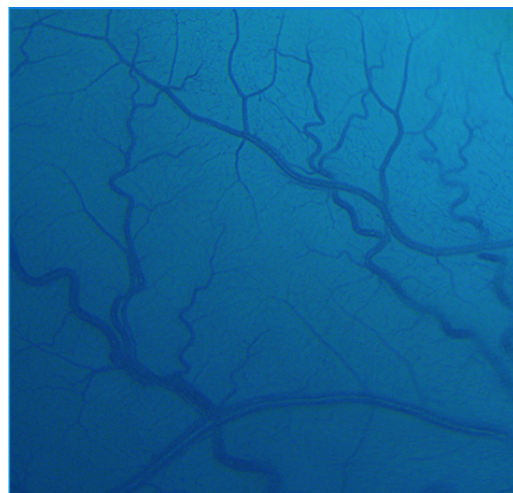
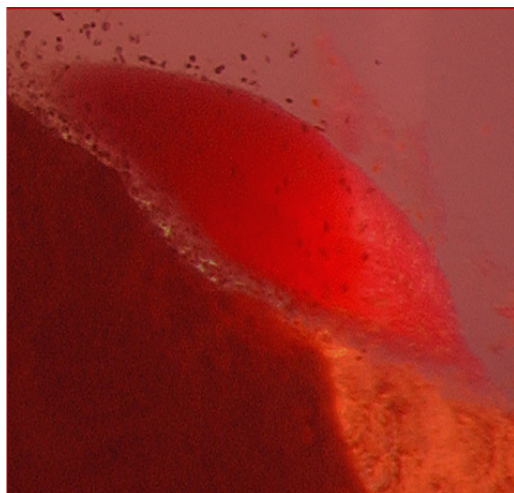
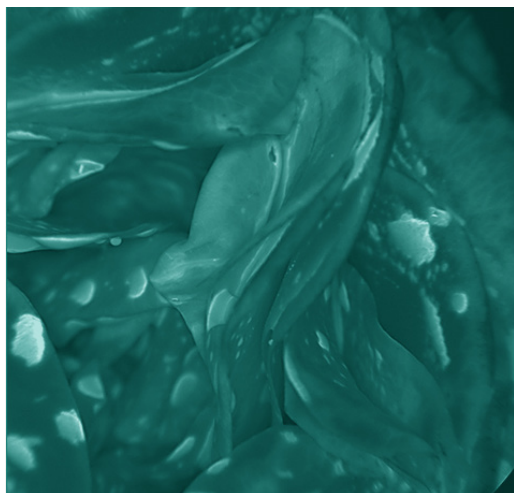
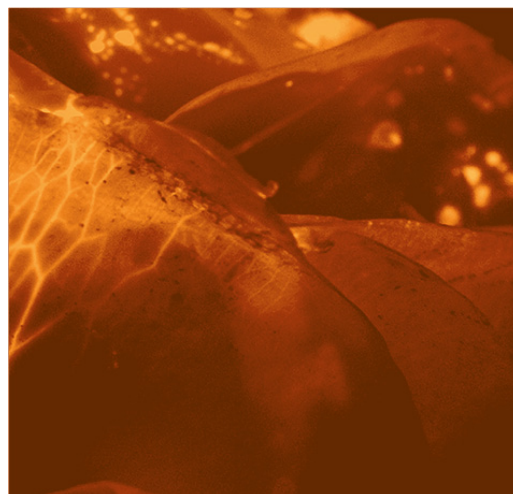
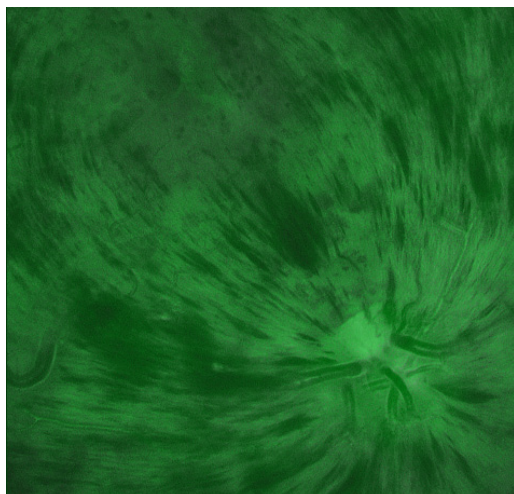
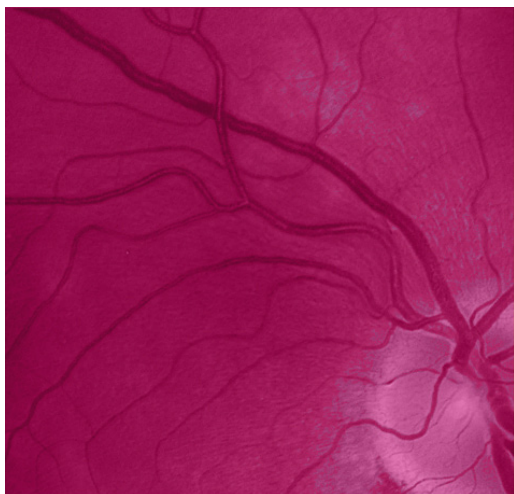


# KRESGE EYE INSTITUTE



PATIENT INFORMATION PACKET

# KRESGE EYE INSTITUTE

## Patient Appointment Information

**Date of Appointment**  **Time**

**Doctor**

**Location**  Bingham Farms  Dearborn  Dearborn Retina  Detroit (*main office*)

Lake Orion  Sinai-Grace Hospital  Southfield  Taylor  Troy

Warren  Ypsilanti

If you are unable to keep your appointment, please call **313.577.8900** 24 hours in advance.

### What to Expect

As our patient, you will receive the finest ophthalmic care available. For your convenience, all examinations, diagnostic testing and medical procedures will be performed in one location and on the same day as your appointment. The entire process will take two to four hours to complete and will reduce the need for multiple visits.

During your visit your pupils may be dilated. While dilated your eyes will be sensitive to light and you may experience blurred vision for several hours. It may be beneficial to have someone with you to drive you home.

### What to Bring

- Picture ID (Driver's License or State ID)
- Social security card
- Insurance cards (all valid and current)
- A list or the bottles of the medications you are currently taking
- Your glasses and/or contact lenses
- Insurance payment authorization forms  
*If your insurance is through an HMO or Point of Service program, your insurance company may require you to have all services authorized in advance. Please have your authorization in hand or sent to us prior to your appointment. Otherwise, your appointment will need to be rescheduled.*

### Financial Information

At the time of your appointment, co-payments, non-covered service fees and deductibles are collected, unless prior arrangements are made. For your convenience payment may be made with cash, personal check, Visa, MasterCard, American Express or Discover.

Please note that a fee of \$30 will be charged if a refraction (checking vision with different lenses in an attempt to improve vision) is performed.

### **For nursing home or group home patients, the following also applies:**

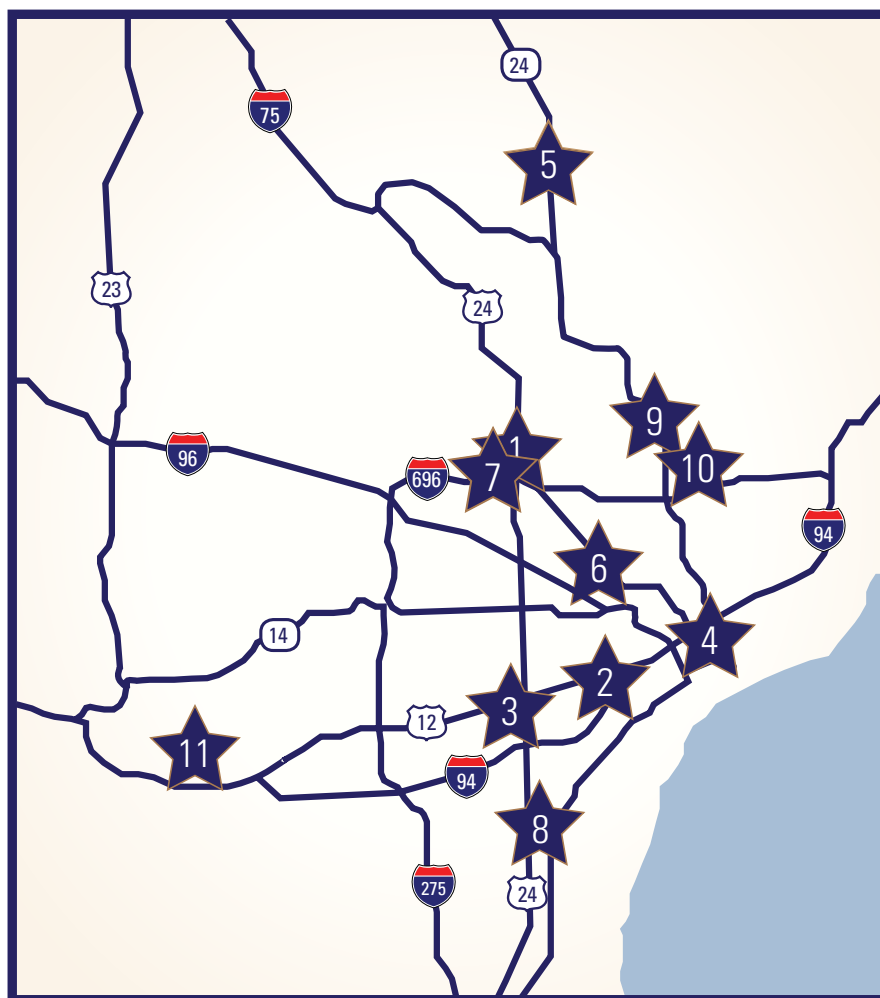
- Attendant must accompany and remain with the patient throughout the visit
- Copies of patient ID card and insurance card must be provided
- Please bring all patient information at the time of your visit

***Please refer to the map on the reverse for directions to your appointment.***

The expertise of

# KRESGE EYE INSTITUTE

In your neighborhood



Current Locations:

1. Bingham Farms  
31500 Telegraph Rd., Ste 005  
Bingham Farms, MI 48025

2. Dearborn  
4700 Schaefer Rd., Ste. 260  
Dearborn, MI 48126

3. Dearborn Retina  
25230 Michigan Avenue  
Dearborn, MI 48124

4. Detroit  
4717 St. Antoine  
Detroit, MI 48201

5. Lake Orion  
1455 South Lapeer Rd.  
Lake Orion, MI 48360

6. Sinai Grace Hospital  
6071 W. Outer Drive, Ste. M-106  
Detroit, MI 48235

7. Southfield  
26400 W. 12 Mile Rd., Ste. 20  
Southfield, MI 48034

8. Taylor  
15055 Plaza South Dr.  
Taylor, MI 48180

9. Troy  
1560 E. Maple Rd, Suite 200  
Troy, MI 48083

10. Warren  
28800 Ryan, Ste. 100  
Warren, MI 48092

11. Ypsilanti  
5333 McAuley, Dr., Ste. 4011  
Ypsilanti, MI 48197

# Registration Form



University  
Physician Group

Date \_\_\_\_\_

## Patient Information

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Last Four Digits of SSN: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ County: \_\_\_\_\_

**Ethnicity:**  Hispanic, Latino or Spanish origin  Non Hispanic, Non Latino or Non Spanish origin

**Race:**  African American/Black  Caucasian/White  Middle Eastern  Asian  Greek  Hispanic  Indian  
 More than one race  Native American Indian  Native Hawaiian or other Pacific Islander

**Marital Status:**  S  M  D  W **Gender:**  M  F

**Preferred Language:** \_\_\_\_\_ **Interpreter Need:**  Y  N

**Insurance Guarantor:**  Self  Parent  Other \_\_\_\_\_

Patient Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer's Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Preferred Method of Communication:  Home  Work  Cell  Portal  Other: \_\_\_\_\_

Would like to receive appointment reminders and promotional text messages:  Yes  No

E-Mail Address: \_\_\_\_\_

### Legal Guardian - 1

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Address Same as Patient

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

### Legal Guardian - 2

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Address Same as Patient

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

**Emergency Contact Name:** \_\_\_\_\_

Emergency Contact Phone Number: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Do you have an **Advance Directive** or a formal document indicating who your Durable Power of Attorney is for health care decisions?  Yes  No

If no, would you like the physician to provide you information on Advance Health Care Directives?  Yes  No

### Pharmacy

**We are now able to transmit your prescriptions electronically. Please list your pharmacy information below:**

Local Pharmacy: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

(street address if known or main road with closest cross street)

Mail Order Pharmacy: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

How did you hear about us?  Physician  Family  Friend  Website  Advertisement  Attorney

Other: \_\_\_\_\_

# Registration Form

## Primary Care Family Physician

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_

## Referring Physician Is My Primary Family Physician

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_

**Primary Insurance:** \_\_\_\_\_ Group # \_\_\_\_\_ ID# \_\_\_\_\_

Subscribers Relationship to Patient:  Self  Parent  Spouse  Other \_\_\_\_\_

Subscriber Name: \_\_\_\_\_

SSN of Subscriber if Veteran's Insurance: \_\_\_\_\_ Subscriber Date of Birth: \_\_\_\_\_

Sex of Subscriber:  Male  Female Subscriber Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_ Group # \_\_\_\_\_ ID# \_\_\_\_\_

Subscribers Relationship to Patient:  Self  Parent  Spouse  Other \_\_\_\_\_

Subscriber Name: \_\_\_\_\_

SSN of Subscriber if Veteran's Insurance: \_\_\_\_\_ Subscriber Date of Birth: \_\_\_\_\_

Sex of Subscriber:  Male  Female Subscriber Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Other Insurance:**  Vision  Dental  Other Medical \_\_\_\_\_

Subscribers Relationship to Patient:  Self  Parent  Spouse  Other \_\_\_\_\_

Subscriber Name: \_\_\_\_\_

SSN of Subscriber if Veteran's Insurance: \_\_\_\_\_ Subscriber Date of Birth: \_\_\_\_\_

### If patient is being seen due to injury please complete the following:

\_\_\_\_\_ Injury at work Date: \_\_\_\_\_ From a  lift  twist  fall  bend  pull  reach

Claim number: \_\_\_\_\_

Name and number of case worker/adjuster: \_\_\_\_\_

\_\_\_\_\_ Auto Accident Date of Accident: \_\_\_\_\_ State of Injury: \_\_\_\_\_

Claim number: \_\_\_\_\_

Name and number of case worker/adjuster: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name(s) of Legal Guardian: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Responsible Party Signature: \_\_\_\_\_ Relationship: \_\_\_\_\_

*(if patient is minor or has guardian)*





# WAYNE STATE UNIVERSITY PHYSICIAN GROUP

## GENERAL CONSENT FOR TREATMENT, RELEASE OF MEDICAL INFORMATION, AND FINANCIAL RESPONSIBILITY

Print Patient Name (Last, First, Middle Initial)

Date of Birth

### **PLEASE READ HIS ENTIRE GENERAL CONSENT PRIOR TO SIGNING**

#### **GENERAL CONSENT FOR MEDICAL SERVICES**

I give permission to the physicians, employees, and other people who work for or represent Wayne State University Physician Group ("WSUPG") to provide me with health care services. These services could include things such as tests to determine whether I am sick, physical exams, surgery, and normal medical tests and procedures (e.g., blood tests or flu shots). My physician will help me decide what services or supplies I will need. I understand that WSUPG's physicians, employees and other people who work for or represent WSUPG make no promises about the type of results I may have from any of these medical services or treatments. I also understand that WSUPG helps train physicians and other health care professionals and that students and physicians-in-training might be involved in my medical care.

If my physician thinks I should have a specific medical or surgical procedure, I understand that my physician will describe this procedure to me and explain how it will help me. I also understand that my physician will tell me about the negative things that could happen as a result of the procedure, as well as any other types of treatments or procedures that could help me.

#### **CONSENT FOR BLOOD-BORNE INFECTIOUS DISEASE TESTING**

I give permission to WSUPG to test me for an infectious disease in my blood. Infectious diseases that can be carried in the blood include hepatitis, Acquired Immune Deficiency Syndrome ("AIDS"), and Human Immunodeficiency Virus ("HIV"). I understand that the results of these tests will be put in my medical record and will be kept private. I also understand that if I do not give permission to WSUPG to do these tests, WSUPG cannot refuse to provide me health care services, just because I did not agree to have these blood tests.

- Yes, I give permission to WSUPG to test me for an infectious disease in my blood.
- No, I do not give permission to WSUPG to test me for an infectious disease in my blood.

#### **CONSENT TO RELEASE OF MEDICAL INFORMATION**

I understand that my medical information may be used by WSUPG and shared with other people or organizations, such as my insurance company and other health care providers, if the information is needed for reasons related to treatment, payment, or health care operations. I also understand that WSUPG might need information from other people or organizations that have already given me medical care. If WSUPG needs that information to help give me medical care now, I give permission to those other people or organizations, such as a hospital, another physician, a managed care company, or a pharmacy, to give WSUPG any and all of my medical information, including any information that is on paper and in a computer. I understand that the WSUPG Notice of Privacy Practices has more information about how my medical information could be used and shared.

**ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES**

By checking one of the boxes below, I am stating that:

- I have received a copy of the WSUPG Notice of Privacy Practices.
- I have been given the opportunity, but do not want to receive a copy of the WSUPG Notice of Privacy Practices.

**ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY**

In exchange for the medical services provided to me by WSUPG and its physicians, I agree to pay the WSUPG medical bills when they are due, even if the services I receive will not be paid for by my insurance company. If I am late in paying the WSUPG bills, and my account is given to a lawyer or a collection agency, I understand and agree that I will be responsible for paying the attorney’s fees, court costs, and any financial penalties the collection agency and/or court may award to help collect the amount(s) I owe to WSUPG. I understand that my insurance company may require that I get permission before I receive health care services from WSUPG, and it will be my responsibility to make sure I get this permission from the insurance company. When WSUPG bills me for medical services that are not paid for by my insurance, I agree that I will pay those bills to WSUPG.

**ASSIGNMENT OF BENEFITS**

I give WSUPG the right to receive all of the money that my insurance company would normally pay to me for any services I receive from WSUPG. I understand that any positive balance in my WSUPG account may be used by WSUPG to pay any amount I owe WSUPG for services I receive. If there is any amount remaining in my account after paying for what I owe, WSUPG will pay (refund) that amount to me.

**CONTINUING AGREEMENT**

I understand that the information in this General Consent form describes the relationship between me, the patient, and WSUPG, the health care provider. I agree that the terms of this consent will continue to apply to me and will remain in effect during the time that I am being cared for by WSUPG and its physicians, even though my treatment may involve more than one visit to WSUPG/its physicians and may last for a period of time.

*By signing below, I am saying that I have read and understand this General Consent, and I agree that the terms will apply to me. I understand that I have a right to take away (withdraw) my consent/authorization at any time, unless WSUPG has already done something based on my earlier consent/authorization or WSUPG has the legal ability to do something without my consent/authorization.*

**X** \_\_\_\_\_ (Date)  
(Signature of Patient or Patient’s Legal Representative if Patient is unable to sign)

\_\_\_\_\_  
(Title of Legal Representative/Relationship to Patient unable to sign)

\_\_\_\_\_  
(Address including street, city and zip code)

\_\_\_\_\_  
(Phone Number)

Reason, if Patient is unable to sign:

- Physical/Mental Condition
- Minor (under 18 years old)
- Other: \_\_\_\_\_



# WAYNE STATE UNIVERSITY PHYSICIAN GROUP

## NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

### OUR PLEDGE REGARDING MEDICAL INFORMATION

We are committed to protecting medical information about you. This Notice describes our privacy practices and that of all its employees and staff. This Notice will tell you about the ways in which we may use and disclose medical information about you. It also describes your rights and certain obligations we have regarding the use and disclosure of medical information. We are required by law to:

- Give you this Notice of our legal duties and privacy practices with respect to medical information about you;
- Make sure that medical information that identifies you is kept private; and
- Follow the terms of the Notice that is currently in effect.

### HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways we use and disclose health information that identifies you ("Health Information"). For each category we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

**Treatment.** We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose your Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who need the information to provide you with medical care.

**Payment.** We may use and disclose your Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about services you received at our office so your health plan will pay us or reimburse you for the services.

**Health Care Operations.** We may use and disclose Health Information for health care operations. These uses and disclosures are necessary to make sure that our patients receive quality care and to operate and manage our office. For example, we may use Health Information to review our treatment and services and to evaluate the performance of our staff in caring for you.

**Business Associates.** We may disclose Health Information to our contracted Business Associates that perform functions on our behalf. For example, we may use another company to perform billing services.

**Appointment Reminders, Treatment Alternatives and Health-Related Benefits and Services.** As part of treatment activities or health care operations, we may use your Health Information to contact you as a reminder that

you have an appointment with us. We also may use Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

**Fundraising.** We may use and disclose limited Health Information to send you fundraising communications. You have the right to "opt-out" of receiving these communications at any time.

**Individuals Involved In Your Care or Payment for Your Care.** When appropriate, we may share your Health Information with a person who is involved in your medical care or payment of your care, such as your family or a close friend, so long as you have not objected and it is reasonable for us to believe that such disclosure is in your best interest. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

**Research.** Under certain circumstances, we may use and disclose Health Information for research activities. For example, a research project may involve comparing the health of patients who received another treatment for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process.

**Special Purposes When Permitted or Required by Law.** We may disclose Health Information about you for special purposes when permitted or required by law, including the following:

- To avert a serious threat to health or safety against you, the public, or another person.
- For public health and administrative oversight activities such as disease control, abuse or neglect reporting, health and vital statistics, audits, investigations, and licensure reviews.
- For organ and tissue donation and transplant activities.
- For workers' compensation or similar programs purposes, such as for the payment of benefits for work-related injuries.
- To coroners, medical examiners, and funeral directors to identify a deceased person, determine cause of death, or to carry out duties.
- For judicial and administrative proceedings in response to a subpoena, court order, or administrative order, if certain requirements are met.
- For law enforcement activities, if the disclosure is required by law, necessary to identify or locate a suspect or missing person, about criminal conduct on our premises, about inmates, about victims of crime under certain circumstances, and in certain emergency situations.
- For U.S. military and veteran reporting obligations regarding members and veterans of the armed forces of U.S. or foreign military.



- For national security and intelligence activities, such as protective services for the President and other authorized persons.
- When otherwise required by law.

**State and Other Federal Laws.** We will comply with all applicable state and federal laws. *For example, under Michigan law, there are more limits on the disclosure of mental health information, substance abuse information, and HIV and AIDS information.* We will continue to abide by all applicable state and federal laws.

**Other Uses of Medical Information Require an Authorization.** Other uses and disclosures of your Health Information that are not covered by this Notice will be made only with your authorization, including for marketing purposes or sale of Health Information. A written authorization is also required for most uses or disclosures of psychotherapy notes.

If you provide us an authorization to use or disclose your Health Information, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose your Health Information for the reasons covered by the written authorization. You understand that we are unable to take back disclosures we have already made with your authorization, and that we are required to retain our records of the care that we provide to you.

**HEALTH INFORMATION EXCHANGE**

We may participate in a health information exchange organization (“HIE”) that permits computer-based transfer of Health Information directly between healthcare providers at different locations and institutions to facilitate your care and treatment. If you do not want your Health Information to be shared in this way, you can opt-out.

**YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU**

You have many rights with regard to your Health Information. If you wish to exercise any of these rights, we ask that you submit your request in writing.

**Your Right to Access.** You have the right to inspect and obtain a copy of your Health Information. This includes medical and billing records. You have the right to request this information in a particular electronic form or format. You also have the right to request that we transmit a copy of your Health Information directly to you or another person designated by you. We have up to 30 days to make your Health Information available to you and we may charge a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or other state or federal need-based program. We may deny your request in certain limited circumstances.

**Your Right to Amend.** If you feel that your Health Information is incorrect or incomplete, you may ask us to amend the information. You have the right to add a statement. You must provide a reason that supports your request for an amendment.

**Your Right to an Accounting of Disclosures.** You have the right to request a list of certain disclosures we made of your Health Information. This is referred to as an

“accounting of disclosures.” Your request must state a time period. We may limit the time period to the prior 6 years. The first list you request within a 12-month period is free. For additional lists, we may charge you for the costs of providing the list.

**Your Right to Request Restrictions.** You have the right to request a restriction or limitation on the how we use or disclose your Health Information for treatment, payment or operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care, like a family member or friend. We have the right to deny your request, except if you have paid for the service out of pocket in full and you request that we not submit your information to your health plan. In this case, we must agree to the request.

**Your Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. We will not ask you the reason for your request.

**Right to Paper Copy of this Notice.** You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time.

**Right to File a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with WSUPG. You may also file a complaint directly with the Secretary of the Department of Health and Human Services. You will not be penalized in any way for filing a complaint.

**Your Right to Receive Notice of a Breach.** You have the right to be notified of a breach of your unsecured Health Information. We will notify you by mail at your last known address.

**CHANGES TO THIS NOTICE**

We reserve the right to make changes to this Notice. We reserve the right to make the revised Notice effective for Health Information we already have about you, as well as information we receive in the future. We will post a copy of the current Notice at our offices and make copies available upon request.

**PRIVACY NOTICE CONTACT INFORMATION**

For questions about any information contained in this Privacy Notice, contact:

Privacy Officer  
540 E. Canfield  
Scott Hall, Room 1374  
Detroit, MI 48201  
Tel: (313) 577-0558

**CLINIC/PHYSICIAN CONTACT INFORMATION**

For all other questions, contact:

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