

WELCOME TO OUR PRACTICE

We look forward to meeting you and caring for your eyes. Below you will find a list of items that we require for your next visit:

- 1) Bring your **Medical and Vision Insurance** cards-we cannot bill your insurance company without them.
- 2) Bring your **driver's license** or some form of picture ID (if you do not have a driver's license).
- 3) Make certain a referral **has been generated** if you have an HMO (or a Point of Service that requires one).
- 4) Bring your **eyeglasses** even if you wear contact lenses.
- 5) Wear your **contact lenses** (if applicable) if you would like us to renew your current prescription. Please bring any information that you might have on your current contacts.

Co-payments, refraction and contact lens fittings/evaluation fees: are due on the date of service.

Contact Lens Services: Please notify us in advance if you currently wear contact lenses or wish to be fitted for them. We need to allow the proper amount of time for this kind of appointment. There is an additional charge for contact lens fittings and evaluations.

Medical Exams: If your visit is for a known or suspected eye disease or injury, we will bill your medical insurance.

Routine Exams: If your visit is routine, (new glasses), we will bill your vision Plan.

Optical: If you are interested in eyewear, we have a large selection at very competitive prices. Come in and browse our optical during your visit. Our optical participates with many vision insurance plans, including Blue Cross Vision, DMC Heritage Optical, MEBS, MECA, VSP, Vision Care Plan, EyeMed (Select and Access Plans), Aetna Vision, and Harrington UMR Vision.

Just a note: We do our best to understand the many insurance benefits that our patients carry. Of course the expert about *your* own plan should be you! Please become familiar with your insurance so that you understand referrals (if required), co-pay and benefit levels. Your knowledge assists us in submitting a claim on your behalf. We promise to do our best to make your visit in our office as pleasant and convenient as possible.

Please complete the enclosed pre-registration forms and return them in our self-addressed stamped envelope.

Sincerely,

Carl F. Clavenna, M.D.
Gregory B. Fitzgerald, M.D.
Bianca Bilek, O.D.
And Staff

Vision Insurance VS Medical Insurance

What is the difference? We hope we can clarify this question for you.

Your vision insurance is a "rider" that either you or your employer purchases to receive coverage for a routine eye exam and glasses or contact lenses. Medical insurance is intended to cover services when a medical condition exists.

How do I know if my visit is medical or vision?

Your vision insurance would apply for a routine eye examination if you:

- Have no known problems with your eyes except for needing new glasses.

AND

- Were not referred by another physician.

AND

- Your previous eye examinations by Dr. Clavenna, Dr. Fitzgerald, or Dr. Bilek did not show any medical conditions.

If the above does not apply then we need to address the medical condition and use your medical insurance.

Examples of medical conditions: Cataracts, glaucoma or suspicion of glaucoma, macular degeneration, implants, red eyes, tearing, irritation, pain, etc.

Dr. Bilek, our optometrist, will see our patients for routine vision exams and contact lens appointments. Patients will be referred by Dr. Bilek to our ophthalmologists if there is a medical diagnosis. Our patients will continue to be under the care of our ophthalmologists Dr. Clavenna and Dr. Fitzgerald for any medical conditions.

It is your responsibility to:

- ✓ Know your insurance
- ✓ Know if you need a referral
- ✓ Know if your Doctor is in Network
- ✓ Pay your copay at time of service

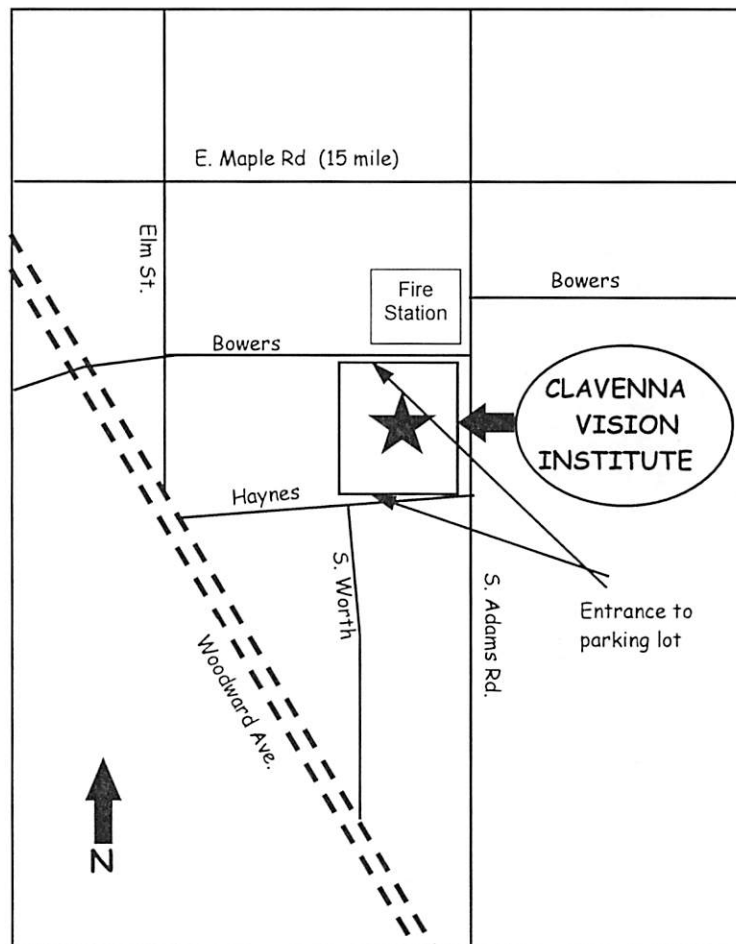
It is nearly impossible for us to know every insurance plan available to our patients.

THANK YOU!

CLAVENNA VISION INSTITUTE

THE MOST TRUSTED CARE IN SIGHT

600 S. Adams Rd., Suite 200
Birmingham, MI 48009



248-646-3733

PATIENT INFORMATION

NAME _____ (Dr. Mr. Mrs. Miss Ms.) circle one BIRTHDATE _____

Circle preferred phone #

SOCIAL SECURITY # _____ HOME PHONE _____ CELL PHONE _____

ADDRESS _____ CITY _____ ST _____ ZIP _____

E-MAIL ADDRESS _____

PATIENT EMPLOYER _____ PHONE # _____

EMERGENCY CONTACT _____ PHONE _____ ALTERNATE PHONE _____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

PRIMARY CARE PHYSICIAN _____ ADDRESS _____

CITY _____ STATE _____ ZIP _____ PHONE _____

PRIMARY INSURANCE

SUBSCRIBER'S NAME _____ RELATIONSHIP TO PATIENT _____ BIRTHDATE _____

SOCIAL SECURITY # _____ HOME PHONE _____ CELL PHONE _____

SUBSCRIBER'S EMPLOYER _____ WORK PHONE _____

INSURANCE: Medicare (please circle) or Other: _____

SECONDARY INSURANCE

SUBSCRIBER'S NAME _____ RELATIONSHIP TO PATIENT _____ BIRTHDATE _____

SOCIAL SECURITY # _____ HOME PHONE _____ CELL PHONE _____

SUBSCRIBER'S EMPLOYER _____ WORK PHONE _____

INSURANCE: Medicare (please circle) or Other: _____

OTHER or VISION INSURANCE

SUBSCRIBER'S NAME _____ RELATIONSHIP TO PATIENT _____ BIRTHDATE _____

SOCIAL SECURITY # _____ HOME PHONE _____ CELL PHONE _____

SUBSCRIBER'S EMPLOYER _____ WORK PHONE _____

INSURANCE : _____

GUARANTOR INFORMATION -same as patient YES _____ NO _____ please complete if No is your answer

GUARANTOR'S NAME _____ RELATIONSHIP TO PATIENT _____ BIRTHDATE _____

SOCIAL SECURITY # _____ HOME PHONE _____ CELL PHONE _____

EMPLOYER _____ WORK PHONE _____

Financial Policy :I hereby authorize the release of the necessary medical information to process claims and direct payment of benefits to Clavenna Vision Institute. I understand I am responsible to pay all non-covered services, co-pays, and deductibles. I understand if my insurance requires a referral authorization and I fail to bring a referral, I will be responsible for all charges. If my account falls in arrears, I agree to reimburse Clavenna Vision Institute the fees of any collection agency at a maximum percentage of 26% of the debt, and all costs and expenses, including reasonable attorney fees, associated with such collection efforts. I understand and agree to this financial policy.

SIGNATURE OF PATIENT, GUARANTOR (IF PATIENT IS A MINOR), _____ DATE

LEGAL GUARDIAN OR LEGAL REPRESENTATIVE

UPDATE SIGNATURES (FOR FUTURE APPOINTMENTS)

Signature	Date	Signature	Date
Signature	Date	Signature	Date

This signature page is designed for you to establish limitations on what information we can share with people **other than your insurance company or Drs. who coordinate your care.** If you have certain family members or caregivers that normally assist you in either your health care decisions or financial decisions, you may wish to include them in Section "A" of this form. **If you do not authorize anyone in section "A" be aware that we will not be allowed to answer any questions regarding your care, including billing, to anyone but you** (including your spouse, siblings, adult children, and caregivers).

AUTHORIZATION TO RELEASE RECORDS

I AUTHORIZE THE PERSON(S) NAMED BELOW TO DISCUSS MY CARE IN MY ABSENCE AND OBTAIN MY MEDICAL RECORDS IF NECESSARY. **(THIS DOES NOT INCLUDE DOCTORS WHO ARE INVOLVED IN MY CARE).** I UNDERSTAND THIS AUTHORIZATION IS IN EFFECT UNLESS I REVOKE THE AUTHORIZATION IN WRITING.

DESCRIPTION OF THE SPECIFIC INFORMATION TO BE DISCLOSED:

ALL MEDICAL RECORDS

Section A

NAME	RELATIONSHIP	PHONE

PATIENT SIGNATURE

DATE

PAST MEDICAL, FAMILY, SOCIAL HISTORY AND REVIEW OF SYMPTOMS

Date _____

Patient Name _____ Acct # _____ Date of Birth _____

Medication allergies and your reaction: _____

Known allergy to Latex- YES [] NO [] Are you pregnant YES [] NO [] Are you nursing YES [] NO []

PAST OCULAR HISTORY & SURGERIES: Have you had any of the following:

YES NO

- Glaucoma
- Lazy Eye
- Macular Degeneration
- Cataracts

CURRENT EYE MEDICATIONS AND DOSAGES: _____

PAST MEDICAL AND SURGICAL HISTORY-Have you had any of the following:

YES NO

- Breathing/Lung Disease- Specify _____
- Liver Disease
- Kidney Disease
- Hypertension
- Stroke
- Heart Disease
- Thyroid
- High Cholesterol

YES NO

- Autoimmune disease Crohns MS
- Fibromyalgia Rheumatoid Arthritis
- Sarcoid Lupus Other _____
- HIV/AIDS
- Cancer - specify _____
- Diabetes - age diagnosed _____
Type I or II (circle)
- Insulin Dependant

CURRENT MEDICATIONS and VITAMINS (including over the counter) AND DOSAGES: _____

FAMILY HISTORY-Have any family members had the following:

YES NO

	Relation If grandparent, list maternal or paternal	Living:	YES	NO
<input type="checkbox"/> <input type="checkbox"/> Arthritis	_____		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> Blindness	_____		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> Cancer	_____		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> Cataracts	_____		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> Diabetes	_____		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> Glaucoma-	_____		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> Heart Disease	_____		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> High Blood Pressure	_____		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> Kidney Disease	_____		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> Lazy Eye	_____		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> Macular Degeneration	_____		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> Retinal Disease	_____		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> Stroke	_____		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> Tuberculosis	_____		<input type="checkbox"/>	<input type="checkbox"/>

SOCIAL HISTORY-Do you or have you used the following:

YES NO

Drugs
If Yes, What Drug: _____

YES NO

Current Tobacco User
 Former Tobacco User

YES NO

Alcohol
If Yes, how much: _____

If former tobacco user, when did you quit: _____

Please answer the following questions: (you have the option to choose not to answer)

What is your preferred Language _____ I prefer not to answer

What race are you:

- American Indian or Native Alaskan
- Asian
- African American
- Pacific Islander
- Caucasian
- I prefer not to answer

Are you Hispanic or Latino YES NO
I prefer not to answer _____

REVIEW OF SYSTEMS

Date _____

Patient Name _____ Acct # _____ Date of Birth _____

Are you experiencing any of the following:

EYES	YES	NO	RESPIRATORY	YES	NO	BLOOD/LYMPHNODES	YES	NO
Previous Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Cough	<input type="checkbox"/>	<input type="checkbox"/>	Easy bruising	<input type="checkbox"/>	<input type="checkbox"/>
Contact Lens	<input type="checkbox"/>	<input type="checkbox"/>	Congestion	<input type="checkbox"/>	<input type="checkbox"/>	Gums bleed easily	<input type="checkbox"/>	<input type="checkbox"/>
Pain	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Prolonged bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Heavy aspirin use	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>						
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	GASTROINTESTINAL	YES	NO	MUSCULOSKELETAL	YES	NO
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	Stiffness	<input type="checkbox"/>	<input type="checkbox"/>
Dry Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Nausea/vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Flashes	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice/hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Joint pain/swelling	<input type="checkbox"/>	<input type="checkbox"/>
Floaters	<input type="checkbox"/>	<input type="checkbox"/>						
			URINARY	YES	NO	SKIN	YES	NO
EARS,NOSE,THROAT	YES	NO	Pain or difficulty urinating	<input type="checkbox"/>	<input type="checkbox"/>	Rash/sores	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty hearing	<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	Lesions	<input type="checkbox"/>	<input type="checkbox"/>
Ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>	History of kidney stones	<input type="checkbox"/>	<input type="checkbox"/>	Hives/eczema	<input type="checkbox"/>	<input type="checkbox"/>
Vertigo	<input type="checkbox"/>	<input type="checkbox"/>	History of sexually transmitted diseases	<input type="checkbox"/>	<input type="checkbox"/>			
						NEUROLOGICAL	YES	NO
CARDIOVASCULAR	YES	NO				Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	PSYCHIATRIC	YES	NO	Weakness/paralysis	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety/depression	<input type="checkbox"/>	<input type="checkbox"/>	Numbness	<input type="checkbox"/>	<input type="checkbox"/>
Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	Mood swings	<input type="checkbox"/>	<input type="checkbox"/>	Tremors	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty sleeping	<input type="checkbox"/>	<input type="checkbox"/>	Dementia	<input type="checkbox"/>	<input type="checkbox"/>
Irregular heartbeat	<input type="checkbox"/>	<input type="checkbox"/>				IMMUNOLOGICAL	YES	NO
Difficulty lying flat	<input type="checkbox"/>	<input type="checkbox"/>	ENDOCRINE	YES	NO	Hives	<input type="checkbox"/>	<input type="checkbox"/>
			Increased thirst	<input type="checkbox"/>	<input type="checkbox"/>	Itching	<input type="checkbox"/>	<input type="checkbox"/>
CONSTITUTIONAL	YES	NO	Increased hunger	<input type="checkbox"/>	<input type="checkbox"/>	Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue/weakness	<input type="checkbox"/>	<input type="checkbox"/>	Increased urination	<input type="checkbox"/>	<input type="checkbox"/>	Sinus pressure	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Increased sweating	<input type="checkbox"/>	<input type="checkbox"/>			
Weight gain or loss	<input type="checkbox"/>	<input type="checkbox"/>	Fingernail changes	<input type="checkbox"/>	<input type="checkbox"/>			