



Les D. Grosinger, M.D., F.A.C.S.
Alan V. Spigelman, M.D., F.A.C.S.
David S. Grey, M.D., F.A.C.S.

Diplomates American Board of Ophthalmology

Dear New Patient:

Welcome to the practice of Grosinger, Spigelman & Grey, MD.

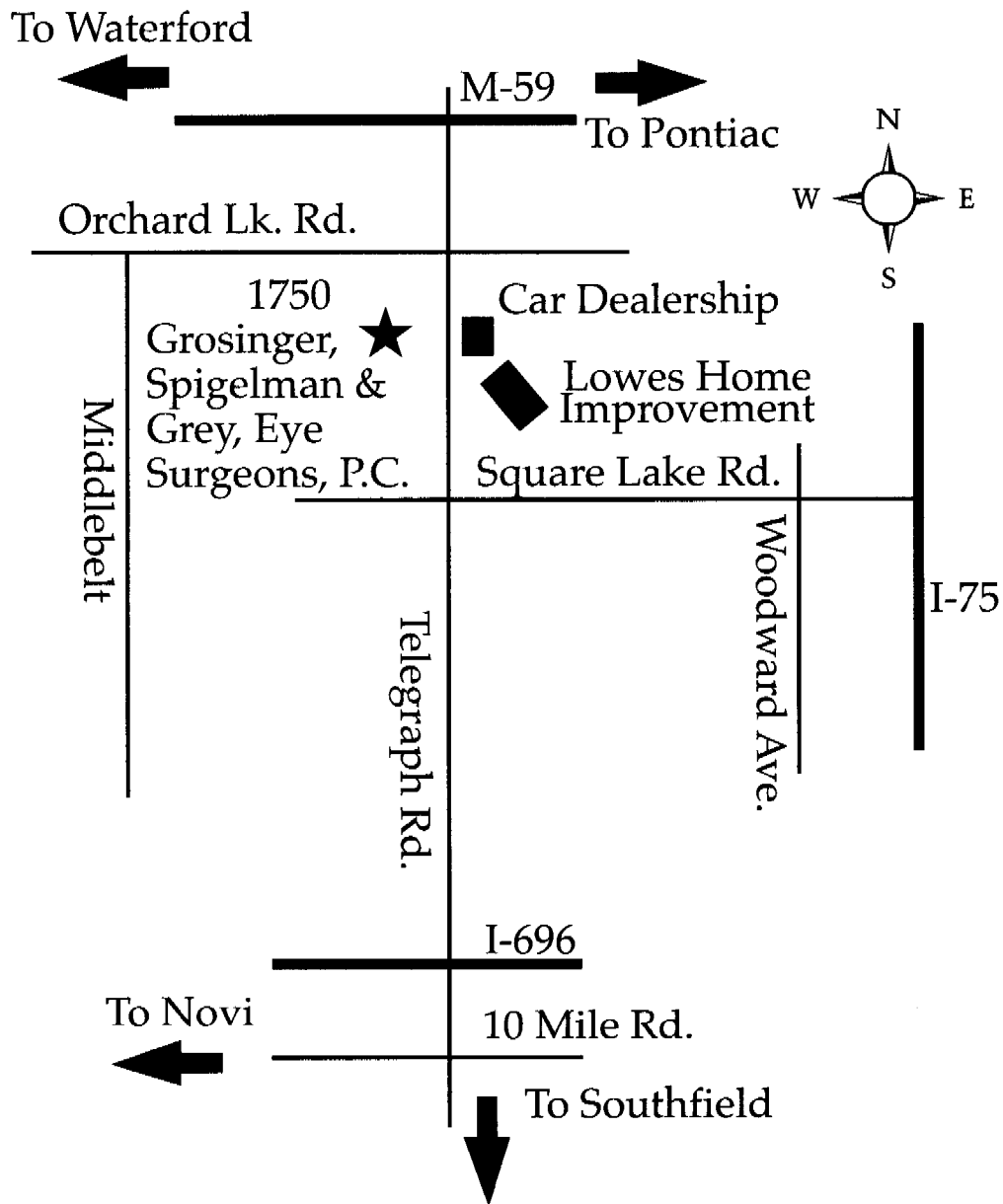
Enclosed you will find: a map to the office, a new patient data form, and possibly a medicare consent form. Please fill out the patient data form in full and bring it with you to your appointment. You should also bring the following items: a list of all current medications, sunglasses (if you have them), all insurance cards so we may bill directly and, if you are insured by a HMO, please obtain an authorization prior to coming to the office. This referral/authorization may be mailed prior to your appointment, faxed or hand delivered to our office.

Your visit to the office will be approximately 1 1/2 - 2 hours. If other testing and/or procedures are necessary, your visit could run longer. Please arrange other appointments accordingly. Please keep in mind that Dr. Grosinger, Dr. Spigelman & Dr. Grey are specialists, and as specialists they do have occasional emergency visits. We apologize in advance if your appointment is delayed for this reason.

As a new patient, the doctor will be dilating your pupils. This dilation will cause your near vision to become blurry and make you sensitive to the sunlight. It is your decision to determine whether you should bring someone to drive you home.

We are located at 1750 S. Telegraph Rd., Suite 205. We are approximately 1-1/4 mile north of Square Lake Road on the west side of Telegraph, directly across from the Car dealership, between the House of Bedroom showrooms and Carl's Golfland.

If you should have any questions, please do not hesitate to contact the office between 8 am – 5 pm Monday through Thursday or 8am – 4pm on Friday at (248) 333-2900. We thank you for your attention and look forward to meeting you.



Located at 1750 Telegraph Road approximately
1 mile north of Square Lake Road

MEDICAL HISTORY QUESTIONNAIRE

Date of **Birth** _____ Date of **last eye exam** _____

List any **medications** you currently take (Prescription and over-the-counter): _____

Have you **ever** taken a medication call Flomax? YES NO

Name of Medical Drs.: _____

Do you have **allergies** to any medications? YES NO

 If YES, list the medications: _____

List all **major illnesses** (glaucoma, diabetes, high blood pressure, pacemaker, heart attack, etc.) or **injuries** (concussion, etc.): _____

List any **surgeries** you have had (tonsillectomy, appendectomy): _____

List any **eye surgeries** (i.e. cataract, LASIK, PRK): _____

Do you **currently** have any problems in the following areas? If YES, please explain.

	YES	NO	Details
EYES			
Loss of vision			
Blurred vision			
Fluctuating vision			
Distorted vision			
Glare or light sensitivity			
Loss of side vision			
Double vision			
Dryness			
Mucous discharge			
Redness			
Sandy or gritty feeling			
Itching			
Burning			
Foreign body sensation			
Excess tearing or watering			
Eye pain or soreness			
Floaters			
Flashing lights			
Infection of eye or lid			
Tired eyes			
Crossed eyes, lazy eye			
Drooping eyelid			
GENERAL / CONSTITUTIONAL (fever, weight loss, other)			
EARS, NOSE, THROAT (stuffy nose, ear ache, cough, dry mouth, etc.)			
CARDIOVASCULAR (high BP, racing pulse, etc.)			
RESPIRATORY (congestion, wheezing, etc.)			
GASTROINTESTINAL (stomach upset, diarrhea, constipation, etc.)			

	YES	NO	Details
GENTRAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, etc.)			
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, etc.)			
SKIN (pimples, warts, growths, rash, etc.)			
NEUROLOGICAL (numbness, headache, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
BLOOD / LYMPH (cholesterolemia, anemia, etc.)			
ALLERGIC / IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, etc.)			

FAMILY HISTORY		M=Mother F= Father S=Sibling GP=Grandparent		
DISEASE	YES	NO	Relationship to Patient	
Blindness				
Glaucoma				
Arthritis				
Cancer				
Diabetes				
Heart disease or high blood pressure				
Kidney disease				
Lupus				
Stroke				
Thyroid disease				
Other				

SOCIAL HISTORY

Current occupation: _____

Marital status (married, divorced, single, widowed): _____

Do you drive?.....YES NO

Do you have visual difficulty when driving?.....YES NO

Do you have problems with night vision?YES NO

Have you ever tried to wear contact lenses?YES NO

Do you currently wear contact lenses?YES NO ⇒ If YES, how long? _____

Do you currently wear glasses?YES NO ⇒ If YES, how long have you had your current prescription? _____

Have you ever had a blood transfusion?YES NO

Do you drink alcohol?.....YES NO If YES: occasional 1 /day 2-3 /day 4+ /day

Do you smoke?YES NO If YES: occasional 1/2 pk/day 1 pk/day 2+pk/day

Print Name _____

Signature _____ Date _____



Les D. Grosinger, M.D., F.A.C.S.
Alan V. Spigelman, M.D., F.A.C.S.
David S. Grey, M.D., F.A.C.S.

Diplomates American Board of Ophthalmology

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION (PHI)

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 goal is to take appropriate steps to attempt to safeguard any medical or other personal information that is provided to us. The Privacy Rule under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires us to: (i) maintain the privacy of medical information provided to us; (ii) provide notice of our legal duties and privacy practices; and (iii) abide by the terms of our Notice of Privacy Practices currently in effect.

WHO WILL FOLLOW THIS NOTICE

• **This notice describes the practices of our employees and staff as well as our computer and billing vendor. This notice applies to each of these individuals, entities, sites and locations. In addition, these individuals, entities, sites and locations may share medical information with each other for treatment, payment and health care operation purposes described in this notice.**

INFORMATION COLLECTED ABOUT YOU

In the ordinary course of receiving treatment and health care services from us, you will be providing us with personal information such as:

- Your name, address and phone number.
- Information relating to your medical history.
- Your insurance information and coverage.
- Information concerning your doctor, nurse or other medical providers.

We may disclose health information about you when we are required to do so by federal, state, or local law.

We may disclose protected health information about you in connection with certain public health reporting activities. For instance, we may disclose such information to a public health authority authorized to collect or receive PHI for the purpose of preventing or controlling disease, injury or disability, or at the direction of a public health authority, to an

official of a foreign government agency that is acting in collaboration with a public health authority. Public health authorities include state health departments, the Center for Disease Control, the Food and Drug Administration, the Occupational Safety and Health Administration and the Environmental Protection Agency, to name a few.

We are also permitted to disclose protected health information to a public health authority or other government authority authorized by law to receive reports of child abuse or neglect. Additionally we may disclose protected health information to a person subject to the Food and Drug Administration's power for the following activities: to report adverse events, product defects or problems, or biological product deviations; to track products; to enable product recalls, repairs or replacements; or to conduct post marketing surveillance. We may also disclose a patient's health information to a person who may have been exposed to a communicable disease or to an employer to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether an individual has a work-related illness or injury.

We may disclose a patient's health information where we reasonably believe a patient is a victim of abuse, neglect or domestic violence and the patient authorizes the disclosure or it is required or authorized by law.

We may disclose health information about you in connection with certain health oversight activities of licensing and other health oversight agencies which are authorized by law. Health oversight activities include audit, investigation, inspection, licensure or disciplinary actions, and civil, criminal, or administrative proceedings or actions or any other activity necessary for the oversight of 1) the health care system, 2) governmental benefit programs for which

health information is relevant to determining beneficiary eligibility, 3) entities subject to governmental regulatory programs for which health information is necessary for determining compliance with program standards, or 4) entities subject to civil rights laws for which health information is necessary for determining compliance.

We may disclose your health information as required by law, including in response to a warrant, subpoena, or other order of a court or administrative hearing body or to assist law enforcement identify or locate a suspect, fugitive, material witness or missing person. Disclosures for law enforcement purposes also permit use to make disclosures about victims of crimes and the death of an Individual, among others.

We may release a patient's health information (1) to a coroner or medical examiner to identify a deceased person or determine the cause of death and (2) to funeral directors. We also may release your health information to organ procurement organizations, transplant centers, and eye or tissue banks, if you are an organ donor.

We may release your health information to workers' compensation or similar programs, which provide benefits for work-related injuries or illnesses without regard to fault.

Health information about you also may be disclosed when necessary to prevent a serious threat to your health and safety or the health and safety of others.

We may use or disclose certain health information about your condition and or administrative tribunal. We may also release protected health information in the absence of such an order and in response to a discovery or other lawful request, if efforts have been made to notify you or secure a protective order.

If you are an inmate, we may release protected health information about you to a correctional institution where you are incarcerated or to law enforcement officials in treatment for research purposes where an Institutional Review Board or a similar body referred to as a Privacy Board determines that your privacy interests will be adequately protected in the study. We may also use and disclose your health information to prepare or analyze a research protocol and for other research purposes.

If you are a member of the Armed Forces, we may release health information about you for activities deemed necessary by military command authorities. We also may release health information about foreign military personnel to their appropriate foreign military authority.

We may disclose your protected health information for legal or administrative proceedings that involve you. We may release such information upon order of a court certain situations such as where the information is necessary for your treatment, health or safety, or the health or safety of others.

Finally, we may disclose protected health information for national security and intelligence activities and for the provision of protective services to the President of the United States and other officials or foreign heads of state.

Our Business Associates. We sometimes work with outside individuals and businesses that help us operate our business successfully. We may disclose your health information to these business associates so that they can perform the tasks that we hire them to do. Our business associates must promise that they will respect the confidentiality of your personal and identifiable health information.

Disclosures to Persons Assisting in Your Care or Payment for Your Care. We may disclose information to individuals involved in your care or in the payment for your care. This includes people and organizations that are part of your "circle of care" – such as your spouse, your other doctors, or an aide who may be providing services to you. We may also use and disclose health information about a patient for disaster relief efforts and to notify persons responsible for a patient's care about a patient's location, general condition or death. Generally, we will obtain your verbal agreement before using or disclosing health information in this way. However, under certain circumstances, such as in an emergency situation, we may make these uses and disclosures without your agreement.

Appointment Reminders. We may use and disclose medical information to contact you, by mail or phone or leave a message for you as a reminder that you have an appointment or that you should schedule an appointment.

Treatment Alternative. We may use and disclose your personal health information in order to tell you about or recommend possible treatment options, alternatives or health-related services that may be of interest to you.

OTHER USES AND DISCLOSURES OF PERSONAL INFORMATION

We are required to obtain written authorization from you for any other uses and disclosures of medical information other than those described above. If you provide us with such permission, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose personal information about you for the reasons covered by your written authorization, except to the extent we have already relied on your original permission.

INDIVIDUAL RIGHTS

You have the right to ask for restrictions on the ways we use and disclose your health information for treatment, payment and health care operation purposes. You may also request that we limit our disclosures to persons assisting your care or payment for your care. We will consider your request, but we are not required to accept it.

You have the right to request that you receive communications containing your protected health information from us by alternative means or at alternative locations. For example, you may ask that we only contact you at home or by mail. Except under certain circumstances, you have the right to inspect and copy medical, billing and other records used to make decisions about you. If you ask for copies of this information, we may charge you a fee for copying and mailing. If you believe that information in your records is incorrect or incomplete, you have the right to ask us to correct the existing information or add missing information. Under certain circumstances, we may deny your request, such as when the information is accurate and complete.

You have a right to receive a list of certain instances when we have used or disclosed your medical information. We are not required to include in the list uses and disclosures for your treatment, payment for services furnished to you, our health care operations, disclosures to you, disclosures you give us authorization to make and uses

and disclosures before April 14, 2003, among others. If you ask for this information from us more than once every twelve months, we may charge you a fee.

You have the right to a copy of this notice in paper form. You may ask us for a copy at any time. You may also obtain a copy of the form at our web site at WWW.EYEMICHIGAN.COM.

To exercise any of your rights, please contact us in writing at:

Grosinger, Spigelman & Grey Eye Surgeons, P.C.

Attn: Office Manager

1750 Telegraph Rd

Suite 205

Bloomfield Hills, MI 48302

When making a request for amendment, you must state a reason for making the request.

CHANGES TO THIS NOTICE

We reserve the right to make changes to this notice at any time. We reserve the right to make the revised notice effective for personal health information we have about you as well as any information we receive in the future. In the event there is a material change to this notice, the revised notice will be posted. In addition, you may request a copy of the revised notice at any time.

COMPLAINTS/COMMENTS

If you have any complaints concerning our privacy practices, you may contact the Secretary of the Department of Health and Human Services, at 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201 (e-mail:ocrmail@hhs.gov). You also may contact us at 248-333-2900 or in writing at: Grosinger, Spigelman & Grey Eye Surgeons, P.C.

Attn: Office Manager

1750 Telegraph Rd

Suite 205

Bloomfield Hills, MI 48302

YOU WILL NOT BE RETALIATED AGAINST OR PENALIZED BY US FOR FILING A COMPLAINT.

To obtain more information concerning this notice, you may contact our Privacy Officer at the phone or address above.

This notice is effective as of 4-1-2003.



Les D. Grosinger, M.D., F.A.C.S.
Alan V. Spigelman, M.D., F.A.C.S.
David S. Grey, M.D., F.A.C.S.

Diplomates American Board of Ophthalmology

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

I, _____, HAVE RECEIVED A COPY OF
(PRINT NAME)
THE NOTICE OF PRIVACY PRACTICES FOR THE OFFICE OF GROSINGER,
SPIGELMAN & GREY EYE SURGEONS, P.C.

(PATIENT OR PERSONAL REPRESENTATIVE SIGNATURE)

*(RELATIONSHIP)

(DATE)

***IF PERSONAL REPRESENTATIVE'S SIGNATURE APPEARS ABOVE, PLEASE DESCRIBE RELATIONSHIP TO PATIENT.**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ___ Individual refused to sign
- ___ Communication barriers prohibited obtaining the acknowledgement
- ___ An emergency situation prevented us from obtaining acknowledgement
- ___ Other (Please Specify)

(Employee's Name Printed)

(Employee's Signature)

(Date)

PATIENT DATA FORM

Please fill out completely and sign bottom, Thank you

Name _____ SS# _____
Address _____ City _____ State _____ Zip _____
Phone # _____ Birthdate _____ Sex – Male / Female
Cell # _____ E-mail address _____

Alternate contact person – other than the home phone #:

Name/Relationship _____ Phone# _____

Marital status: Single Married Divorced Widowed

Spouse name _____

If a minor --- Guardian / Parents name _____

Insurance information:

Cardholders name and relationship to patient _____

SS# _____ Birthdate _____

Are you – Employed / Disabled / Retired / Other _____

If you are retired is your spouse still employed? YES / NO

If you are employed – occupation _____

Name of employer _____

Phone # _____

Referred By: _____

It is my responsibility to provide all necessary insurance information to process payment of my claim. I authorize payment of my insurance benefits to be made directly to my doctor. As a courtesy, the doctors office will submit my claims to my insurance carriers, but I understand that I am financially responsible for all services rendered not covered or payable by my insurance carrier including deductibles, co-payments or non-covered services.

If I need an authorization/referral, it is my responsibility to obtain it from my primary care physician prior to my appointment or I will be held responsible for payment of services rendered.

Patients who have BCBS Mastermedical, no office visit coverage or have no insurance will be expected to pay in full at the time medical services are rendered.

Signature _____ Date _____

No Changes Signature _____ Date _____

No Changes Signature _____ Date _____

Signature on File, Assignment of Benefits, Financial Agreement

Beneficiary Name *(print)* _____

Medicare Number _____

1. **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to Grosinger, Spigelman & Grey Eye Surgeons, P.C., for services furnished me by Grosinger, Spigelman & Grey Eye Surgeons, P.C. I authorize any holder of medical information about me to release to the Centers for 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 to the insurer or agency shown. Grosinger, Spigelman & Grey Eye Surgeons, P.C. 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.

2. **MEDIGAP:** I understand that if a MediGap policy or other health insurance is indicated in Item 9 of 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 Grosinger, Spigelman & Grey Eye Surgeons, P.C., if possible or otherwise to me.

3. **RELEASE OF INFORMATION:** Grosinger, Spigelman & Grey Eye Surgeons, P.C. 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 Grosinger, Spigelman & Grey Eye Surgeons, P.C. for reimbursement for services rendered, and (2) any health care provider for continued patient care. Grosinger, Spigelman & Grey Eye Surgeons, P.C. 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, statute or regulation. A copy of this authorization may be used in place of the original.

4. **OTHER INSURANCE:** I understand that Grosinger, Spigelman & Grey Eye Surgeons, P.C. 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 Grosinger, Spigelman & Grey Eye Surgeons, P.C. 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 Grosinger, Spigelman & Grey Eye Surgeons, P.C. if I belong to a plan that does not appear on the above mentioned list.

5. **NON-COVERED SERVICES:** I understand that Grosinger, Spigelman & Grey Eye Surgeons, P.C.'s contracts with health care service plans (i.e., HMOs, PPOs) relate only to items and services which are covered by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service 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 Grosinger, Spigelman & Grey Eye Surgeons, P.C. to obtain necessary health care service plan authorizations.

6. **FINANCIAL AGREEMENT:** I agree that in return for the services provided to the patient by Grosinger, Spigelman & Grey Eye Surgeons, P.C., I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Grosinger, Spigelman & Grey Eye Surgeons, P.C. 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 Grosinger, Spigelman & Grey Eye Surgeons, P.C. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Grosinger, Spigelman & Grey Eye Surgeons, P.C. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

Beneficiary Signature or Authorized Party _____

Date _____

Prescriptions for eyeglasses are not covered by Medicare/Medical insurance.