CENTER ROAD EYE INSTITUTE

3364 South Center Road, Burton, MI 48519
(810) 743-3937 ~ (810) 743-9210 fax

Thank you for choosing us for your eye care needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following information. If you have any questions, please do not hesitate to ask.

When preparing to come in the office for your appointment please remember to bring with you…

- The completed welcome packet forms. *If you misplace these forms go to www.centerroadeye.com and click on the patient center button under the online forms click on download and print the forms. Or you can arrive 15 minutes early to complete the forms here in the office. *
- A current copy of your medication list. Do not bring your pill bottles.
- Your ID/driver's license, medical insurance cards, routine vision insurance cards and for all Blue Care Network patients a required referral from your insurance company. (you have to request a referral authorization from your primary care physician)

Please also note…

- Any co-pay/non insurance covered charges will be due at the time of service. (Except for Medicare patients) You will be mailed any other balance owed determined by your insurance company after we receive your "explanation of payment" from your insurance carrier.
- *Our doors open at the office hour start time (8am or 9am) not before that time and we see all patients according to their scheduled appointment time not first come first served.*
- Our office closes for lunch 12:15 – 1:15 pm Monday - Friday. *When the office resumes office hours at 1:15pm we will follow the same policy, the doors open at 1:15 and we only go by scheduled appointment times.*
- If you cannot keep your scheduled appointment please call the office within 24 hours of your appointment time to avoid a $25.00 no show fee. Also, it is company policy that after 3 no show appointments we will no longer be able to schedule any more appointments.

COVID-19 update

- When arriving for your appointment please call the office from the parking lot and let the receptionist know you have arrived. They will advise when it is safe for you to enter the building. Once inside the building they will ask you to wear a mask (if you have a health condition that prevents you to wear one just notify the staff) we will have you hand sanitize and they will check your temperature. Then they will start the check in process. Per government order we are also only allowed to have the patient and one other person for every exam. All chairs are 6 feet apart for your safety and extra sanitizing steps are being done for every patient.
- Per Governmental orders we have restrictions of how many people can be in our building at the same time as well as requirements on social distancing. To follow those orders, we have locked the doors to try to control this process. It is also required to have an appointment for all office services. This includes all optical services including pickups and repairs. For any questions please call the office. If you want to drop off any paperwork or payments we encourage to mail, email or call the office. For the email option you can email info@centerroadeye.com.

Welcome to Center Road Eye Institute

We are a part of your Patient-Centered Medical Home Neighborhood!

We are partnering with your Primary Care Physician as they build your Medical Home. We are sharing their commitment to effectively and efficiently co-manage your care over-time. As your Specialist, we will be sharing limited or long-term management (depending on the nature and impact) of your condition and provide advice, guidance and periodic follow-up until the crisis or treatment has been stabilized or completed.

You may notice that:

- We will be communicating with your Primary Care Physician (PCP) and will be providing timely written reports on our consultations with you to them.
- We will be notifying your PCP of no-shows, cancellations and other actions that may place your care in jeopardy.
- We will be providing future scheduled appointments and treatment plans.
- We will be notifying your PCP of referrals needed for other Specialties.

We trust you, our patient, to:

- Keep your appointments as scheduled, or call and let us know when you cannot to avoid a no-show fee
- Learn about your insurance, so you know what it covers
- Learn about wellness and how to prevent disease
- Seek the advice of your PCP before you see other physicians.
- Follow the care plan that is agreed upon-or let us know why you cannot so that we can try to help, or change the plan
- Tell us what medications you are taking and ask for a refill at your office visit when you need one
- See your PCP on an annual basis for all preventive services

We will continue to:

- Remind you when tests are due so that you can receive the best quality care
- Ask you to have blood tests done before your visit so that the doctor has the results at your visit

Center Road Eye Institute
Dr. Timothy G. McNally, DO
Dr. John F. Labaza, OD

3364 S. Center Road

Burton, MI 48519

(810) 743-3937

A Patient-Centered Medical Home (PCMH) is a system of care in which a team of health professionals' work together to provide all of your health care needs. You, the patient, are the most important part of a patient-centered medical home. When you take an active role in your health and work closely with us, you can be sure that you're getting the care you need.

AFTER HOURS CARE

IF YOU HAVE AN EMERGENCY HEALTH CARE NEED AFTER-HOURS, PLEASE CALL OUR OFFICE AND SELECT THE EMERGENCY OPTION AND YOU CAN CALL DR. MCNALLY. OR CONTACT YOUR PRIMARY CARE/FAMILY PHYSICIAN TO GUIDE YOUR CARE.

TEST RESULTS

PLEASE TRY TO USE LABORATORIES AND OTHER TEST FACILITIES WE USE REGULARLY TO ENSURE BETTER COMMUNICATION. WE STRIVE TO GET TEST RESULTS TO PATIENTS. IF YOU HAVE NOT RECEIVED A CALL OR NOTIFICATION BY MAIL WITHIN 14 DAYS AND/OR DO NOT HAVE A FOLLOW-UP APPOINTMENT, PLEASE CALL THE OFFICE FOR YOUR RESULTS.

AVAILABLE COMMUNITY SERVICES

NEED HELP? 2-1-1 IS NOW AVAILABLE IN GENESEE COUNTY! DIAL 211 FROM ANY PHONE AND YOU WILL BE CONNECTED WITH A REFERRAL HOTLINE THAT CAN CONNECT YOU WITH NON-PROFIT AGENCIES IN THE AREA THAT CAN HELP WITH HUMAN, HEALTH AND SOCIAL NEEDS (I.E., UTILITIES, HOUSING, HEALTH INSURANCE, FOOD, DIAPERS, ETC.)

A LISTING OF THE AREA RESOURCES CAN ALSO BE FOUND ON THIS WEBSITE:
www.mi211.org
or
PLEASE ASK OUR STAFF FOR INFORMATION PERTAINING TO YOUR SPECIFIC NEEDS.

PATIENT WEB-PORTAL

WE HAVE A PATIENT PORTAL THAT SUPPORTS TWO-WAY, SECURE & COMPLIANT COMMUNICATION. IF YOU WOULD LIKE TO ACCESS YOUR MEDICAL INFORMATION, PLEASE ASK US HOW TO DO SO.

PRACTICE HOURS

Monday, Wednesday, Thursday
8:15 am* – 5pm
Tuesday & Friday
9am* – 5pm, 8:15 am – 3pm
Office closes for lunch 12:15 – 1:15
**Doors open at scheduled office hours (may change without notice) and Will see all patients in order of the scheduled appointment times, not first come first served*

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Welcome to or back to our office and thank you for choosing us for your eye care needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following information. If you have any questions, please do not hesitate to ask.

Last Name _____

First Name _____ **Middle Initial** _____ **Suffix** _____

Salutation - Dr. Miss Mr. Mrs. Ms.

Preferred Name _____ **Address** _____

Date of Birth _____ _____ _____ _____

City State Zip

Social Security Number _____ _____ _____

Home Phone Number **Day Phone Number**

Communication preference – **Phone or Email** **Email** -_____ ○ **Permission to send emails?**

(Please circle your preference) ○ **Would you like to receive a copy of your exam or patient education forms?**

Government is requiring that we ask the following questions. If you choose not to answer please check "I do not want to specify" Thank You.

Ethnicity – Hispanic or Latino / Not Hispanic or Latino / Unknown

Race – Black or African American / White / Caucasian / Native American / American Indian or Alaskan Native / Asian / Native Hawaiian or other Pacific Islander / Other _____ ___ I do not want to specify

Preferred Language __English/Other_____

Gender ○ Male ○ Female **Blood Pressure _____/_____** **Height - _____ Weight _____**

Guardian/Representative _____ **Emergency Contact**_____

Employer _____ **School** _____ _____

Emergency Contact Phone Number

Primary Care Physician _____ PCP **phone number** _____

Pharmacy _____ Phone number_____

Who referred you here today?_____

INSURANCE - PLEASE GIVE YOUR CARDS TO FRONT DESK TO BE SCANNED INTO YOUR FILE

INSURANCE COVERAGE- IF INSURED WHO IS THE INSURANCE COVERAGE SUBSCRIBER:

_____ _____ _____

NAME DATE OF BIRTH LAST 4 OF SSN

I understand that the information provided is truthful to the best of my knowledge.

X_____ **Date** _____

→Signature/ Signature of Guardian

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Past Surgeries –

Major Illnesses –

Allergy History –

Current Medication & dosages –

Has your Primary Care Doctor told you that you have any of the following diseases?

EYE DISEASES

- ◯ Yes, ◯ No Amblyopia
- ◯ Yes ◯ No Blepharitis
- ◯ Yes ◯ No Blindness
- ◯ Yes ◯ No Cataract(s)
- ◯ Yes ◯ No Color Blindness
- ◯ Yes ◯ No Diabetic Retinopathy
- ◯ Yes ◯ No Dry Eye Syndrome
- ◯ Yes ◯ No Eye Injuries
- ◯ Yes ◯ No Glaucoma
- ◯ Yes ◯ No Glaucoma Suspect
- ◯ Yes ◯ No High Risk Medication
- ◯ Yes ◯ No Macular Degeneration
- ◯ Yes ◯ No PVD
- ◯ Yes ◯ No Retinal Detachment
- ◯ Yes ◯ No Strabismus
- ◯ Yes ◯ No Other _____

CURRENT EYE SYMPTOMS

- ◯ Yes ◯ No Glare
- ◯ Yes ◯ No Headaches
- ◯ Yes ◯ No Light Sensitivity
- ◯ Yes ◯ No Tired Eyes
- ◯ Yes ◯ No Burning
- ◯ Yes ◯ No Dryness
- ◯ Yes ◯ No Epiphora
- ◯ Yes ◯ No Eyelid Swelling
- ◯ Yes ◯ No Eye Pain or soreness
- ◯ Yes ◯ No Foreign Body
- ◯ Yes ◯ No Infection of Eye Lid
- ◯ Yes ◯ No Itching
- ◯ Yes ◯ No Mucous
- ◯ Yes ◯ No Ptosis (Drooping Eyelids)
- ◯ Yes ◯ No Redness
- ◯ Yes ◯ No Sandy or Gritty Feeling
- ◯ Yes ◯ No Blurred Vision Distance
- ◯ Yes ◯ No Blurred Vision Near
- ◯ Yes ◯ No Distorted Vision
- ◯ Yes ◯ No Flashes of lights
- ◯ Yes ◯ No Floaters or Spots
- ◯ Yes ◯ No Fluctuating Vision
- ◯ Yes ◯ No Loss of Central Vision
- ◯ Yes ◯ No Loss of Side Vision
- ◯ Yes ◯ No Loss of Vision
- ◯ Yes ◯ No Other _____

Check any diseases that someone in your immediate family has been diagnosis with

FAMILY HISTORY

Relationship

- ◯ Yes ◯ No Amblyopia _____
- ◯ Yes ◯ No Blindness_____
- ◯ Yes ◯ No Cataracts _____
- ◯ Yes ◯ No Color Blindness_____
- ◯ Yes ◯ No Eye Tumors _____
- ◯ Yes ◯ No Glaucoma_____
- ◯ Yes ◯ No Glaucoma Suspect_____
- ◯ Yes ◯ No Macular Degeneration_____
- ◯ Yes ◯ No Retinal Detachment_____
- ◯ Yes ◯ No Strabismus _____
- ◯ Yes ◯ No Other Eye Cond._____
- ◯ Yes ◯ No Arthritis_____
- ◯ Yes ◯ No Cancer_____
- ◯ Yes ◯ No Diabetes _____
- ◯ Yes ◯ No Heart Disease _____
- ◯ Yes ◯ No High Blood Pressure_____
- ◯ Yes ◯ No Kidney Disease _____
- ◯ Yes ◯ No Lupus _____
- ◯ Yes ◯ No Stroke _____
- ◯ Yes ◯ No Thyroid Disease _____
- ◯ Yes ◯ No Other Disease _____

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Have you experienced any of these symptoms?

- ○ Yes ○ No Fever
- ○ Yes ○ No Fatigue
- ○ Yes ○ No Hearing Loss
- ○ Yes ○ No Sinus Disorders

Have you had or currently have any of the following?

- ○ Yes ○ No Atrial Fibrillation
- ○ Yes ○ No Heart Disease
- ○ Yes ○ No Hypertension
- ○ Yes ○ No Stroke/TIA
- ○ Yes ○ No Asthma
- ○ Yes ○ No Emphysema/COPD
- ○ Yes ○ No Shortness of breath
- ○ Yes ○ No Intestinal Conditions
- ○ Yes ○ No Flomax Use
- ○ Yes ○ No Kidney Disease
- ○ Yes ○ No Urinary Conditions/Symptoms
- ○ Yes ○ No Arthritis
- ○ Yes ○ No Muscle/Joint/Back Pain
- ○ Yes ○ No HIV/AIDS
- ○ Yes ○ No TB
- ○ Yes ○ No Herpes
- ○ Yes ○ No Rash/Itching
- ○ Yes ○ No Rosacea
- ○ Yes ○ No Shingles
- ○ Yes ○ No Skin Cancer
- ○ Yes ○ No Multiple Sclerosis
- ○ Yes ○ No Frequent Headaches
- ○ Yes ○ No Convulsions/Seizure
- ○ Yes ○ No Memory Loss
- ○ Yes ○ No Depression
- ○ Yes ○ No Diabetes
  HbA1C _____
- ○ Yes ○ No Thyroid Disease
- ○ Yes ○ No Anemia
- ○ Yes ○ No Cholesterol
- ○ Yes ○ No Seasonal Allergies
- ○ Yes ○ No Lupus
- ○ Yes ○ No Pregnant
- ○ Yes ○ No Nursing
- ○ Yes ○ No Hepatitis
- ○ Yes ○ No Blood Transfusion

Social History –

Current Occupation _____ Years _____ Employer_____

Do you drink alcohol? ○ No ○ Occasional ○ 1 per day ○ 2-3 per day ○ 4+ per day

Do you use illegal drugs? ○ Yes ○ No

Do you engage in regular exercise? ○ Yes ○ No Do you smoke? ○ No ○ current user ○ light user ○ moderate user ○ Heavy user

Do you use nutritional supplements (vitamins etc.)? ○ Yes ○ No

Marital Status (optional) _____ Tobacco use cessation intervention, counseling? ○ Yes ○ No

Tobacco cessation pharmacologic therapy? ○ Yes ○ No

Do you use a computer? ○ Yes ○ No Hours per day _____ Distance from computer _____

Do you drive? ○ Yes ○ No Daily mileage _____ Do you have visual difficulty when driving? ○ Yes ○ No

Do you have glare problems? ○ Yes ○ No Do you have any problems with night vision? ○ Yes ○ No

Do you currently wear glasses? ○ Yes ○ No Since _____ ○ Full Time ○ Part Time ○ Distance ○ Close

Glasses owned ○ Single Vision ○ Safety glasses ○ Bifocals ○ Sports glasses ○ Trifocals ○ Progressive ○ Back-up glasses ○ Other

Have you had trouble in the past with glasses? ○ Yes ○ No If yes, please explain _____

Do you wear sunglasses? ○ Yes ○ No Are your sunglasses your current prescription ○ Yes ○ No

Special Eyewear Needs

- ○ Computer (special prescriptions, special anti-glare tints or coating)
- ○ Safety glasses (gardening, woodworking, welding)
- ○ Occupational (mechanics, plumbers, pilots)
- ○ Sports/Hobbies (racquet sports, motorcycle)

Hobbies/interests _____

Have you tried to wear contact lenses? ○ Yes ○ No Reason for stopping _____

If not a contact lens wearer, are you interested in trying contact lenses at this time? ○ Yes ○ No

Do you currently wear contact lenses? ○ Yes ○ No Since _____

Type and brand of contact lenses _____

How many hours/day? _____ How many days/week? _____ Today's wearing time? _____

What contact lens solution do you use? Cleaner _____ Disinfectant_____

Please rate the following on a scale of 1-10, with 1 being POOR and 10 being EXCELLENT

Lens comfort _____ Right _____ Left Distance Vision _____Right _____ Left Near Vision _____ Right _____Left

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Due to the many changes in insurance policies, it is no longer an easy task to interpret each individual policy. Although we try to stay aware of these changes, it is not always possible.

IT IS YOUR REPSONSIBILITY TO KNOW YOUR INDIVIDUAL COVERAGE.

This includes what procedures are covered, eligibility, waiting periods and deductibles.

Failing to comply could result in you being responsible for all costs incurred. Please remember, your insurance policy is between you are your insurance company- and not with the insurance company and your doctor.

I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

_____

→Patient / Legal Guardian's *Signature* **Date**

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPPA)

I, THE UNDERSIGNED, HAVE READ AND ACKNOWLEDGE THE Notice of Privacy Practices.

_____

Print Full Name, Parent or Personal Representative

_____

→*Signature* of Patient, Parent or Personal Representative **Date**

_____

Personal Representative's relationship to the patient.

OFFICE NO SHOW POLICY-

AFTER 3 NO SHOW APPOINTMENTS WE WILL NO LONGER BE ABLE TO SEE YOU AS A PATIENT.

Initials of the patient _____

I HEREBY AUTHORIZE AND REQUEST THE DOCTORS WITH CENTER ROAD EYE INSTITUTE TO RELEASE INFORMATION TO THE FOLLOWING PEOPLE/PHYSICIAN

_____

_____

→*Signature* of the patient

IF THE PATIENT IS A MINOR, FILL IN THE FOLLOWING INFORMATION		
If the parents are divorced, who is the custodial parent? _____ □ MOTHER □ FATHER □ BOTH		
I hereby authorize and request the doctors with Center Road Eye Institute to examine diagnose and treat the person listed above for whom I am legally authorized to give consent.		
Patient Name		
Parent/Legal Guardian ***Signature***	Relationship to Patient	Date
Parent/Legal Guardian Name (print)	Parent/Legal Guardian's Birth Date	
Parent/Legal Guardian's Social Security Number		

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CONSENT OF MEDICAL BILLING

Dear Patient,

This is a specialist office and the Doctor will perform a complete comprehensive dilated medical examination and will document any medical diagnoses that they find.

Therefore, our office cannot bill your vision insurance for your examination today. Also, the office cannot bill medical and vision insurances for the same office visit. If glasses or contacts are needed the office will bill your routine vision insurance (if eligible) for that purchase.

** If you have not met your medical deductible for the year you will be responsible for your deductible/copay determined by your health insurance plan. If you have any questions or concerns about your cost please contact your medical insurance directly. **

**If you would like to know what your medical diagnosis is or have any questions about your medical diagnosis please ask our physicians before the end of your examination. You can also request a copy of your examination at checkout. **

By my signature below, I acknowledge that I have read and understand the above and have been given the opportunity to ask questions. I confirm that I am the patient, or the patient's authorized representative/guardian.

Patient or Representative Signature _____ Date _____

If signed by someone other than the patient, please specify the relationship to the patient:

_____

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REFRACTION NOTICE:

During examination if the Doctor sees a change in your visual acuity (eye chart test) and feels it is necessary to perform a refraction (new glasses prescription) all Medicare based insurances and some commercial plans are not covering this portion of the exam and charging the patient 100.00 for this service. Dr. McNally will reduce that fee to $35.00 for you.

**All Medicaid insured patients are exempt from this fee.*

Please sign below your acknowledgement of this notice.

Signature _____

Date _____