children's
EYE CARE

PEDIATRIC OPHTHALMOLOGY + ADULT STRABISMUS

John D. Baker, MD
John D. Roarty, MD
Rajesh C. Rao, MD
Lisa I. Bohra, MD
Leemor B. Rotberg, MD
Elena M. Gianfermi, MD
Alexandra O. Apkarian, MD

Welcome!

We would like to thank you for choosing our office for your eye care needs. This information is to assist you with any questions and help you prepare for your visit with us.

Please fill out the enclosed form and bring them with you to your appointment. Also, please bring your insurance card(s), driver's license or identification, patient's glasses/contact lenses and any necessary insurance referrals.

Our appointments are incredibly detailed and we're often even questioning and inquiring about very detailed family, medical and genetic history. Therefore, we prefer the child to be seen with a parent or legal guardian. For the occasional times that's not possible, it's required that you send a note stating the name of the person who will be bringing your child and that it's OK for us to instill dilating drops. The person bringing your child will be required to present us with a Driver's License or State ID to prove his/her identity. We also need to have a number to reach you (the parent or legal guardian) during our entire exam process. Please note we have to refuse examination or treatment if we have any concerns with who is accompanying the child to the appointment.

WHAT TO EXPECT AT YOUR FIRST VISIT: The exam will usually begin with a certified ophthalmic assistant. She/he will perform a history and visual acuity, confrontational visual fields, extra ocular motility, pupil assessment and muscle balance. If there are motility (strabismus) issues, either a certified orthoptist or the doctor will see the patient prior to dilation. None of these tests will hurt or surprise the child. After that, drops will be instilled to dilate the pupils. It usually takes approximately 30 – 45 minutes for the drops to work. This is done so that the doctor can see details about the back of the eye and also the need for glasses can be determined.

The initial appointment will last approximately 2 hours and will include dilation. Dilation typically lasts about 12-24 hours. The patient may be light sensitive and have some difficulty seeing small details up close (usually within arms distance). However, some people have difficulty seeing at farther distances and have difficulty driving. *Please note, with the exception of some adults with strabismus, it's necessary to perform a dilated eye exam on the initial visit. Otherwise, the doctor will not have all of the details necessary to provide advice or treatment suggestions.

Again, thank you for choosing our office. We look forward to meeting you. If you have any questions prior to the visit, please feel free to call us or visit our website at www.childrenseyecaremich.com.

BRING TO YOUR FIRST APPOINTMENT

Cash, check or credit card (MasterCard, Visa or Discover) to pay for any services not covered by your insurance company.
All medical insurance cards (we do NOT participate with vision plans), driver's license or state identification.
Medical History, Authorization to Release HPI
If applicable: Glasses, contact lenses, contact lens box and/or name.
If your insurance company requires authorizations from your primary doctor, remember every visit needs prior approval.
If a patient is a minor, parent or legal guardian must be present at initial visit. A waiver can be signed for subsequent visits but it's always our preference that a parent and/or legal guardian accompanies all children including those old enough to drive themselves.

YOU AND YOUR INSURANCE

CO-PAYS AND DEDUCTIBLES

Our contract with your insurance company requires that we collect any known co-pays and/or deductibles. We are in violation of our contract if we don't collect these fees. We will be collecting these fees at your visit. Please be prepared to pay at this time.

PAYMENT OPTIONS

We accept cash, check and major credit cards (MasterCard, Visa and Discover).

REFRACTIONS

Some insurance companies may not pay for refractions to determine if the patient needs glasses or has a refractive disorder (or pathology). Therefore, it could be an out-of-pocket cost to patients. We will attempt to bill your insurance plans for this test. Our fee is $30.00.

INSURANCE REFERRALS

If your insurance company requires that you obtain referrals or authorizations from your primary care physician (i.e. family doctor, internist), **please request the referral prior to your visit.** You may need to pick the referral up from their office - check with your primary care physician. Also, please remember you will need a referral for every visit.

MEDICAL vs VISION INSURANCE

Our ophthalmologists are medical doctors and will be providing you with a very comprehensive, medical eye exam. We do NOT participate with any vision plans. Therefore, we will be billing your medical insurance for visits related to medical complaints and problems.

If the patient is new, how did you hear of us: **PATIENT REGISTRATION FORM FOR PEDIATRICS**

PATIENT'S LAST NAME	FIRST NAME	MIDDLE	GENDER	BIRTHDATE	SOCIAL SECURITY #

The Center of Medicare and Medicaid Services requires that we collect the patient's race, ethnicity and primary language.

RACE	ETHNICITY	LANGUAGE PREFERENCE:

FULL STREET ADDRESS WHERE PATIENT LIVES	CITY, STATE AND ZIP	WHO DOES PATIENT LIVE WITH? NAME

MOBILE # WHERE PATIENT LIVES	HOME # WHERE PATIENT LIVES	EMAIL ADDRESS	Would you like to communicate with the office via email?
( )	( )		☐ Yes ☐ No
Can you we send you appointment reminders via text message? ☐ Yes ☐ No	OTHER PHONE NUMBER ( )	ALTERNATE PHONE LOCATION □ WORK □ FAMILY/OTHER:_____	

PARENT/GUARDIAN INFORMATION

MOTHER/GUARDIAN'S LAST NAME	FIRST NAME	CHECK ONE	BIRTHDATE	SOCIAL SECURITY #
		□Biological Mother □Adopted Mother □Step-Mother □Foster Mother □Legal Guardian		
EMPLOYER'S NAME	**EMPLOYER'S ADDRESS**		**EMPLOYER'S PHONE #**	
FATHER/GUARDIAN'S LAST NAME	**FIRST NAME**	**CHECK ONE**	**BIRTHDATE**	**SOCIAL SECURITY #**
		□Biological Father □Adopted Father □Step-Father □Foster Father □Legal Guardian		
EMPLOYER'S NAME	**EMPLOYER'S ADDRESS**		**EMPLOYER'S PHONE #**	

PRIMARY DOCTOR OR PEDIATRICIAN'S NAME	ADDRESS/CITY/STATE/ZIP	PHONE NUMBER
REFERRING DOCTOR'S NAME (IF DIFFERENT)	**ADDRESS/CITY/STATE/ZIP**	**PHONE NUMBER**

ARE PARENTS? □ **Married** □ **Separated** □ **Divorced** □ **Single** □ **Widowed** □ **Both Deceased** □ **Legally removed from the child's life**

If the patient is a child not living with both parents, please also provide the address of the parent child doesn't live with:

NAME OF PARENT (child doesn't live with)	ADDRESS/CITY/STATE/ZIP	PHONE NUMBER

AUTHORIZATION TO RELEASE HEALTH INFORMATION & ALLOW OTHERS TO ACCOMPANY MINORS TO APPOINTMENTS

To make it easier to discuss medical care about your child, or you, with those that help you with care, we ask that you complete this form. It is NOT necessary for you to give us permission to talk to any legal parent. We also don't need permission to provide medical information to your other doctors. Example of who needs permission to talk to would be step-parents that haven't legally adopted child, grandparents, aunts/uncles, siblings, friends, the child's school, neighbors, etc. I AUTHORIZE:

PERSON'S NAME:_____ **RELATIONSHIP:**_____ **PHONE #:**_____

PERSON'S NAME:_____ **RELATIONSHIP:**_____ **PHONE #:**_____

PERSON'S NAME:_____ **RELATIONSHIP:**_____ **PHONE #:**_____

PERSON'S NAME:_____ **RELATIONSHIP:**_____ **PHONE #:**_____

I understand that Children's Eye Care (CEC) does NOT participate with VISION insurance. If appropriate, visits will be billed to the medical plan.

CEC 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 CEC for reimbursement for services rendered, and (2) any health care provider for continued patient care. CEC 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, statue or regulation. A copy of this authorization may be used in place of the original. I authorize that my protected health information (also known as PHI) may be used or disclosed with the above-mentioned people. I understand that I have the right to be aware of all PHI that will be disclosed to these people. I understand that Children's Eye Care will not condition any aspect of my treatment or payment I understand that I am under no obligation to sign this Authorization. I understand that this Authorization may be revoked in writing at any time by my signing the revocation section below and returning it to Children's Eye Care unless: they have previously acted in reliance on this Authorization. By my signing the Authorization, I acknowledge that I have read and understand this Authorization. Further, I give my authorization to Children's Eye Care to use or disclose PHI in accordance to the terms of the Authorization. **Financial Agreement:** I agree that in return for the services provided to the patient by CEC, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to CEC 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 CEC. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to CEC. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill. Also, I agree to reimburse CEC the fees of any collection agency , which may be based on a percentage at a maximum of 32% of the debt, and all costs, and expenses, including reasonable attorneys' fees, we incur in such collection efforts.

PATIENT/PARENT/GUARDIAN'S SIGNATURE: _____ DATE:_____

PATIENT/PARENT/GUARDIAN'S PRINTED NAME: _____