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.

What is this Notice and Why Is It Important? By law, Riverside Eye Center, P.C. / MD Eye Center must protect the privacy of your identifiable medical and other health information ("health information").

We are also required by law to give you this notice to tell you how we may use and give out ("disclose") your health information. This notice is effective as of December 18, 2024.

How Riverside Eye Center, P.C. May Use Your Health Information
As a general rule, you must give written permission before your health information can be used or released. There are certain situations where we are not required to obtain your permission. This section explains those situations where your health information may be used or disclosed without permission. Records may also be disclosed electronically as necessary.
Except with respect to Highly Confidential Information (described below), "Riverside" is permitted to use your health information for the following purposes:

Treatment: We use and disclose your health information to provide you with medical treatment or services. This includes uses and disclosures to:
treat your illness or injury, including disclosures to other doctors, practitioners, nurses, technicians or medical personnel involved in your treatment, or contact you to provide appointment reminders, or

● give you information about treatment options or other health related benefits and services that may interest you.

Payment: We may use and disclose your health information to obtain payment for health care services that we or others provide to you. This includes uses and disclosures to:

● submit health information and receive payment from your health insurer, HMO, or other company that pays the cost of some or all of your health care (payer), or verify that your payer will pay for your health care.

Health Care Operations: We may use and disclose your health information for our health care operations, such as internal administration and planning that improve the quality and cost effectiveness of the care we provide you. This also includes uses and disclosures to:

● evaluate the quality and competence of our health care providers, nurses and other health care workers,
● to other health care providers to help them conduct their own quality reviews, compliance activities or other health care operations,
● train students, residents and fellows, or
● identify health-related services and products that may be beneficial to your health and then contact you about the services and products.

We may also disclose your health information to third parties to assist us in these activities (but only if they agree in writing to maintain the confidentiality of your health information). In addition, we may use and disclose your health information under the following circumstances

Relatives, Caregivers and Personal Representatives:

Under appropriate circumstances, including emergencies, we may disclose your health information to family members, caregivers or personal representatives who are with you or appear on your behalf (for example, to pick up a prescription). We may also need to notify such persons of your location in our facility and general condition. If you object to such disclosures, please notify your health care provider. If you are not present, or the opportunity to agree or object to a use or disclosure cannot practicably be provided because of your incapacity or an emergency circumstance, we may exercise professional judgment to determine whether a disclosure is in your best interests. If information is disclosed to a family member, other relative or a close personal friend, we would disclose only information believed to be directly relevant to the person's involvement with your health care or payment related to your health care.

Public Health Activities: We may disclose your health information for the following public health activities:
● To report to public health authorities for the purpose of preventing or controlling disease, injury or disability;
● to report child abuse and neglect to public health authorities or other government authorities authorized by law to receive such reports;
● To alert a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease; or
● To report information to your employer as required under laws addressing work-related illnesses and injuries or workplace medical surveillance.
Victims of Abuse, Neglect or Domestic Violence: If we reasonably believe that you are a victim of abuse, neglect or domestic violence, we may disclose your health information as required by law to a social services or other governmental agency authorized by law to receive such reports.

As Required by Law: We may disclose health information when required to do so by any other law not already referred to in the preceding categories.

Your Written Authorization
FOR ANY PURPOSE OTHER THAN THE ONES DESCRIBED ABOVE WE MAY ONLY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION WHEN YOU GIVE US YOUR WRITTEN AUTHORIZATION.

Highly Confidential Information
Federal and state law require special privacy protections for certain highly confidential information about you ("Highly Confidential Information"), including your health information that is maintained in psychotherapy notes or is about: (1) mental health and developmental disabilities services; (2) alcohol and drug abuse prevention, treatment and referral; (3) HIV/AIDS testing, diagnosis or treatment; (4) communicable disease(s); (5) genetic testing; (6) child abuse and neglect; (7) domestic or elder abuse; or (8) sexual assault. In order for your Highly Confidential Information to be disclosed for a purpose other than those permitted by law, your written authorization is required.

Your Rights Regarding Your Health Information:

Right to Request Access to Your Health Information: You have the right to inspect and maintain a copy of the patient records we maintain to make decisions about your treatment and care, including billing records. All requests for access must be made in writing. Under limited circumstances, we may deny you access to your records. If you would like access to your records, please ask your healthcare provider for the appropriate form to complete. If you request copies, we will charge you a reasonable fee for copies. We also will charge you for our postage costs, if you request that we mail the copies to you. If you are a parent or legal guardian of a minor, certain portions of the minor's medical record may not be accessible to you under state law.

Right to Request Amendments to Your Health Information: You have the right to request that we amend your health information maintained in your medical record file or billing records. If you wish to amend your records, please obtain an amendment request form from your healthcare provider. All requests for amendments must be in writing. We will comply with your request unless we believe that the information that would be amended is already accurate and complete or other special circumstances apply.

Right to Revoke Your Authorization: You may revoke (take back) any written authorization obtained by us for use and disclosure of your protected health information, except to the extent that we have taken action in reliance upon it. Your revocation must be in writing.

Right to Request how Information is Provided to You: You may request, and we will try to accommodate, any reasonable written request for you to receive health information by alternative means of communication or at a different address or location.

Right to Request Restrictions on the use of your Health Information: YOU MAY REQUEST THAT WE RESTRICT THE USE OR DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION. ALL REQUESTS FOR SUCH RESTRICTIONS MUST BE MADE IN WRITING.
While we will consider a request for additional restrictions carefully, we are not required to agree to a requested restriction, except for requests to restrict disclosure of information to a health plan in cases where you have paid for the service out of pocket and in full.

Right to be Notified of Breach: You have the right to be notified by us if we discover a breach of your unsecured protected health information.

Right to a Paper Copy of this Notice: Upon request, you may obtain a paper copy of this Notice, even if you have agreed to receive such information electronically.

RIVERSIDE EYE CENTER/ MD EYE CENTER

MD EYE CENTER

PATIENT REGISTRATION

Today's Date	Name (First , Middle, Last)	Date of Birth

Address	City	State	Zip Code

Male Female Gender at Birth (circle one)	White African American Hispanic Asian Native American Race (circle one or more)

Cell Phone	Social Security
Home Phone	Email Address

Primary Care Doctor	
Name	Address
Phone Number	Fax Number

Referring Doctor	
Name	Address
Phone Number	Fax Number

Emergency Contact	
Name	
Phone	Relationship

Pharmacy	
Name	Address
Phone	

RIVERSIDE EYE CENTER / MD EYE CENTER

MD EYE CENTER

4050 River Rd
East China, MI 48054
810-329-9045

4656 24th Ave
Fort Gratiot, MI 48059
810-385-3600

17900 23 Mile Rd, STE 100
Macomb, MI 48044
586-416-1544

Patient Health Information

Name: (*Last, First, M.I.*)	Birthdate	Today's Date

Thank you for taking your time to carefully complete the patient health information form. This information will be reviewed by the doctor during your examination. All information provided will be held in strict confidence.

PERSONAL MEDICAL/EYE HISTORY

Please note if you have any of the following conditions.

☐ None ☐ Diabetes ☐ High Cholesterol ☐ Macular Degeneration
☐ Cancer ☐ Arthritis ☐ Cataracts
☐ Heart Disease ☐ Dry Eye ☐ Lazy Eye
☐ High Blood Pressure ☐ Glaucoma ☐ Eye Injury
☐ Thyroid Disease ☐ Other_____

- List major injuries and surgeries you have had. _____
  _____
- List all medications you are currently taking (prescription and over-the-counter). _____
  _____
- Do you have any allergies to medications/Latex/Dyes? ☐ Yes ☐ No If yes, please list and describe reaction.
  _____
- Date of your last physical exam _____ Are you pregnant / nursing? ☐ Yes ☐ No
- Have you had your eyes dilated? ☐ Yes ☐ No If yes, were there any problems? _____
- Do you wear glasses? ☐ Yes ☐ No If yes, how old are your glasses? _____
- Date of last complete eye exam _____

FAMILY MEDICAL/EYE HISTORY

Please note any family members with the following conditions. Please also note on the line next to the condition how that person is related to you.

☐ None ☐ Diabetes _____ ☐ High Cholesterol_____ ☐ Macular Degeneration_____
☐ Cancer _____ ☐ Arthritis _____ ☐ Retinal disease_____
☐ Heart Disease _____ ☐ Glaucoma _____ ☐ Lazy Eye _____
☐ High Blood Pressure_____ ☐ Cataracts _____ ☐ Other_____

PERSONAL SOCIAL HISTORY

- Please list your hobbies/recreational activities. _____
- Do you use an electronic device at work/home? ☐ Yes ☐ No If yes, how many hours/day?_____
- Do you drive? ☐ Yes ☐ No If yes, do you have visual difficulty when driving? ☐ Yes ☐ No
- Do you use tobacco products? ☐ Yes ☐ No ☐ Previously: If yes, amount/how long?_____
- Do you drink alcohol? ☐ Yes ☐ No If yes, how often?_____
- Do you use illegal drugs? ☐ Yes ☐ No If yes, how often?_____
- Have you had a blood transfusion ☐ Yes ☐ No If yes, how often?_____
- Have you ever been infected with the following: HIV? ☐ Yes ☐ No TB? ☐ Yes ☐ No Hepatitis? ☐ Yes ☐ No
- Influenza vaccine received? ☐ Yes ☐ No Pneumococcal vaccine received? ☐ Yes ☐ No
- Have you fallen in the past 12 months? ☐ Yes ☐ No

OVER

REVIEW OF SYSTEMS

Please indicate below if you currently have or have in the last month, had any of the following health signs and symptoms:

Eyes

☐ None ☐ Blurred vision ☐ Burning ☐ Eye injury ☐ Light sensitivity/glare
☐ Loss of vision ☐ Dryness ☐ Eye pain ☐ Eye turn
☐ Redness ☐ Excessive tears ☐ Flashes/floaters ☐ Double vision
☐ Itching ☐ Tired/sore eyes ☐ Vision disturbance ☐ Other_____

Constitution

☐ None ☐ Fever ☐ Weight loss ☐ Chills ☐ Other_____

Cardiovascular

☐ None ☐ Chest pain ☐ Palpitations ☐ Lightheaded ☐ Other_____

Ear, Nose, Mouth, Throat

☐ None ☐ Hearing loss ☐ Sinus congestion ☐ Sore throat ☐ Other_____

Respiratory

☐ None ☐ Shortness of breath ☐ Pain when breathing ☐ Chronic cough ☐ Other_____

Gastrointestinal

☐ None ☐ Nausea ☐ Constipation ☐ Diarrhea ☐ Other_____

Genitourinary

☐ None ☐ Increased frequency ☐ Increased urgency ☐ Burning/itching ☐ Other_____

Muscles/Bones/Joints

☐ None ☐ Joint pain ☐ Joint swelling ☐ Restricted motion ☐ Other_____

Skin

☐ None ☐ Rashes ☐ Rosacea ☐ Sores ☐ Other_____

Neurological

☐ None ☐ Headaches ☐ Seizures or Convulsions ☐ Dizziness ☐ Other_____

Psychiatric

☐ None ☐ Anxiety ☐ Depression ☐ Memory loss ☐ Other_____

Endocrine

☐ None ☐ Frequent urination ☐ Elevated blood sugar ☐ Excessive thirst ☐ Other_____

Blood / Lymph

☐ None ☐ Bleeding disorder ☐ Swollen lymph nodes ☐ Low blood count ☐ Other_____

Allergic / Immunologic

☐ None ☐ Seasonal allergies ☐ Suppressed immune system ☐ Allergic rhinitis ☐ Other_____

Please explain any of the signs and symptoms that you checked above:

_____

_____

_____

Riverside Eye Center / MD Eye Center

Advanced Beneficiary Notice (ABN)

Patient Name _____ **Date** _____

Privacy Disclosure

You have the opportunity to object to and revoke the disclosure of my protected health information at any time, but by signing below, I agree to give Riverside Eye Center / MD Eye Center and its staff members permission to use and disclose my protected health information to our staff, other practitioners, insurers, public health agencies, and when required by law. You agree to have us call you regarding your treatment, insurance and or billing information, normal test results and appointment dates. I understand that a message may be left by voice mail, sent by fax, emailed, or left with a family member of your choosing. By submitting this form, I consent to receive SMS text messages from Riverside Eye Center for appointment reminders, marketing messages, and general two-way communication. Msg frequency varies. Msg & data rates may apply. Reply HELP for support. Reply STOP to opt out. Consumer information is not shared with third-parties for marketing purposes.

One Time Authorization Agreement

I request that payment of authorized insurance benefits be made to MD Eye Center for any services furnished to me by this provider. I authorize any holder of medical or other information about me to be released to my insurer and their agents. This includes any information needed to determine these benefits or related services. I permit a copy of the authorization to be used in place of the original. If my insurance fails to pay for a service I understand that I may be responsible for those charges.

Glasses Prescription Agreement

If you are interested in getting your prescription for glasses there may be a $49 charge. This test is not considered a “medical procedure”, therefore most medical insurances will not cover it. **However, If you are here for a routine exam and have separate optical insurance like VSP or Eyemed, the prescription is included with your exam copay and you can ignore this section.** We cannot bill optical and medical insurance on the same day for an exam so if you are here for a medical exam and would still like to get a prescription for glasses, the charge is $49 and will be due today in our optical department. Otherwise you can schedule a separate routine exam with our optometrist. Please indicate your choice below.

☐ I want to receive this service.

☐ I have decided not to receive the service.

Patient Signature _____ **Date** _____

REV 12-24