Naperville Eye Associates

PATIENT INTAKE FORM

Patient First & Last Name: _____ **Date of Birth:** ____/____/_____

Please Circle Sex: Male Female **Please Circle Marital Status:** Single Married Widowed Divorced

CONTACT INFORMATION

Home Address: _____ Apt/Unit: _____
Street

_____
City, State Zip

Preferred Phone Number: _____ **Please circle one:** Cell Home Work

Email Address: _____

MEDICAL CONTACTS

Local Pharmacy: _____
Name Cross Streets, City

Primary Care Doctor: _____ Referring Doctor: _____

EMPLOYMENT

Please Circle Employment Status**:** Full-Time Part-Time Self-Employed Retired Unemployed

Patient Employer: _____ Employer Phone: _____

Employer Address: _____
Street City, State Zip

RESPONSIBLE PARTY & WORKMAN'S COMP
(Insured/Parent/Legal Guardian/Workman's Compensation)

First & Last Name: _____ SSN: _____

Relationship to Patient: _____ Date of Birth: _____/_____/_____

Billing Address: _____
Street City, State Zip

Employer Address: _____
Street City, State Zip

EMERGENCY CONTACT INFORMATION

First & Last Name: _____ Phone Number: _____

Relationship to Patient: _____

First & Last Name: _____ Phone Number: _____

Relationship to Patient: _____

Naperville Eye Associates

FINANCIAL POLICY

Naperville Eye is committed to providing you and your family with quality ophthalmological care. Our staff will strive to help you receive your maximum allowable medical insurance benefits. In order to achieve these goals, we need your assistance and understanding of our financial policy. Ultimately you are financially liable for the cost of services rendered.

INSURANCE PLANS: The physicians at Naperville Eye participate with most major insurance and managed care plans. Due to being a specialist practice, Naperville Eye does not participate with any vision plans. Please contact us at 630-357-5280 to find out if we accept your insurance plan. Please understand our participation with carriers and their specific networks are subject to change which may or may not increase your financial responsibility.

This authorization remains valid and effective from the date of signing until revoked in writing. You represent that you presently maintain insurance which will reimburse Naperville Eye for the medical care provided. Therefore, you hereby assign, transfer and assign to Naperville Eye, all of your right, title and interest in medical reimbursement benefits under your insurance coverages and/or policies.

The patient's/parent's/guardian's responsibility:

- Familiar with the benefits of your insurance plan, including copayments, coinsurance and deductibles and be prepared to pay those financial balances at the conclusion of your visit.
- Bring all your current insurance cards to all visits.
- You understand Naperville Eye's provider network status in your insurance plan.
- Notify us of any changes in your insurance status or insurance company preferably prior to your visit.
- Should there be a delay in your eligibility or there is notification of any change in your insurance information, you will be financially responsible at the time of the visit for full payment. Naperville Eye will refund any overpayment to you upon the reconciliation of your account.

HMO/POS/Referral Care: You must obtain an authorization from your primary care physician prior to your appointment. You will be responsible for any charges above and beyond whatever treatment is listed on the authorization. It is your responsibility to know what services have been authorized and whether the authorization is valid for the date of service. If you choose to be seen without an authorization, you will be responsible for payment at the time of service for those services.

WORKER'S COMPENSATION: All required documents to bill your Worker's Compensation insurance carrier is required at time of service. Otherwise, payment is due at the time of service. If payment is not received from your Worker's Compensation insurance carrier within ninety (90) days, then you are financially responsible for the balance.

COPAYMENTS, DEDUCTIBLES & COINSURANCES: All copayments, deductibles and coinsurance must be paid at each and every visit.

UNINSURED PATIENTS: Full payment is due at time of service. A two-hundred-dollar ($200.00) deposit is due prior to your appointment. This deposit will be applied to your charges. You will be responsible for any balance over the deposit at the time of discharge. If you paid more than the balance on your account, a refund will be processed within 10 business days from the date of service and mailed to the home address on file.

PAYMENTS: We accept Visa, Mastercard, and Discover in addition to cash, or check. You will be financially responsible for all applicable bank service fees for any returned checks.

MEDICARE: The physicians at Naperville Eye participate in Medicare and therefore we accept assignment of services. Medicare pays eighty percent (80%) of what it approves after the annual deductible, and you or your secondary insurance are responsible for twenty percent (20%).

MEDICARE ADVANTAGE PLANS: You understand Medicare Advantage plans are not Medicare. You must abide by the policies and procedures of the Medicare Advantage. Failure to adhere to those policies and procedures may be subject to greater out-of-pocket financial expense.

Flip Over for Requested Signature →

Naperville Eye Associates

ACCOUNT STATEMENTS: You will receive a statement in the mail once your insurance has responded. Your prompt payment in full for any outstanding balance helps us from transferring billing costs. Any past due accounts may be referred to a collection agency after sixty (60) days of billing start date.

CONSENT FOR MINORS: A parent/guardian who brings a minor child to the office shall be responsible for giving consent of treatment, authorizing payment for services, and payment for all fees incurred and owed at the time of service.

OUTSTANDING FINANCIAL BALANCE: All outstanding financial balances must be paid prior to being treated. We will do our best to inform you of any outstanding balance at the time of making your appointment.

BENEFIT ASSIGNMENT: The assignment of benefits of any insurance policy and/or healthcare reimbursement plan shall not be deemed a waiver of Naperville Eye's right to require payment directly from undersigned, the patient or the guardian.

COLLECTION COSTS: Should you fail to reimburse Naperville Eye for services rendered and your balance remains unpaid, this balance will be transitioned to a third-party collection agency for pursual of payment. The undersigned agrees to pay all costs of collections, including and not limited to reasonable legal and third-party fees. If it is necessary to use a collection agency to seek payment for my account, I will be responsible for all fees including collection agency fee (33 1/3%), attorney fees, any court costs and a $25.00 rebilling fee.

EMT/911 SERVICES: If EMT/911 services are required in order to assist you during your encounter, you agree to accept full responsibility for the cost of this assistance to you.

DRIVER'S FIELD EXAM: A Driver's Field Exam is a visual field exam you elect to have done for the provider to complete paperwork provided by the Department of Motor Vehicles in order for you to obtain or renew your driver's license. Regardless of your current medical condition, a Driver's Field Exam is not medically necessary if the exam is not being conducted as a required or recommended component of your office visit. You will be financially responsible for a charge of twenty-five dollars ($25.00). *Please note:* This acknowledgement is ONLY valid when you have a Driver's Field Exam done. This authorization remains on file.

****PLEASE INITIAL THE FOLLOWING:**

_____ (initial) **REFRACTIONS:** A refraction helps to evaluate the health and function of the eyes AND to determine your eye glass prescription. Your doctor may need to perform a refraction to evaluate your eye condition or measurements. <u>The refraction is NOT covered by most insurances and Medicare.</u> You will be financially responsible for a charge of forty dollars ($40.00).

_____ (initial) **MISSED APPOINTMENTS:** Naperville Eye requires at least a 24-hour notice to cancel an appointment. You may be charged a Late Cancellation/No Show fee of fifty dollars ($50.00).

_____ (initial) **MEDICAL RECORDS:** Each patient has a complete record of all medical care received at our office. Because your record is confidential, we will not release your records without your written consent, unless required so by law. There is a twenty-five dollar ($25.00) copying fee if you would like to pick up a copy of your records. If you provide a brand-new USB flash drive, we can upload them at no cost. We will continue to fax your records to your new physician as a courtesy.

I have read and understand the above Naperville Eye financial policy and am aware that I may request a copy of this authorization.

_____ _____

Patient Signature Date

_____ _____

Responsible Party Signature Date

Naperville Eye Associates

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge and understand that, under the Heath Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple heath care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician's certifications.

I have received, read and understand Naperville Eye's posted Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that NEA has the right to change its Notice of Privacy Practices at its discretion and that I may contact NEA at any time using the contact information below to obtain a current copy of the Notice of Privacy Practices. Please note, Naperville Eye prohibits patients' use of photography and/or video or audio recording on the premises.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or heath care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

A copy of our Privacy Practices is available at the front desk via Naperville Eye Associates at 1855 Bay Scott Circle Naperville, IL, 60540. You may request a copy as well by calling: 630-357-5280.

_____ _____

Signature of Patient (or Power of Attorney/Legal Representative) Date

_____ _____

Patient Name (Print) Patient Date of Birth

Naperville Eye has my permission to leave information regarding my medical condition on my:

Home Phone: (_____) _____-_____ Patient's email address: _____

Cell Phone: (_____) _____-_____ Guardian email address: _____

Work Phone: (_____) _____-_____

Naperville Eye has my permission to communicate my health information to the following individuals:

Name: _____ Relation to patient: _____ Phone: _____

Name: _____ Relation to patient: _____ Phone: _____

Naperville Eye Associates

Name: _____ **Date of Birth:** _____

EYE HISTORY

Date of Last Eye Exam:

Currently Wear: ***glasses*** ***contacts*** ***none***

Reason for Today's Visit:

OCULAR MEDICAL HISTORY

Cataracts	yes	no	family
Crossed/Lazy Eye	yes	no	family
Glaucoma	yes	no	family
Macular Degeneration	yes	no	family
Retinal Detachment	yes	no	family
LASIK, PRK, or RK	yes	no	

Other:

Are you currently experiencing any of the following?

- ☐ Blurry Vision ***near*** *or* ***distance***
- ☐ Burning or Gritty
- ☐ Discharge
- ☐ Double Vision
- ☐ Dryness
- ☐ Excess Tearing/Watering
- ☐ Eye Infection
- ☐ Eye Pain or Soreness
- ☐ Floaters
- ☐ Flashes
- ☐ Headaches
- ☐ Itching
- ☐ Light Sensitivity
- ☐ Redness

EYE DROPS (Prescription and over-the-counter)

MEDICATIONS:

☐ Plaquenil/hydroxychloroquine

MEDICAL ALLERGIES:

SURGICAL HISTORY (YEAR):

MEDICAL HISTORY

Diabetes	Type 1	Type 2	No
High blood pressure		Yes	No
High cholesterol		Yes	No
Heart disease		Yes	No
Stroke		Yes	No
Kidney disease		Yes	No
Asthma/COPD		Yes	No
Thyroid dysfunction		Yes	No

Other:

SOCIAL HISTORY

Smoking: **Yes** **No** _____/day Quit ___ years

Drinking: **Yes** **No** _____/day Quit ___ years

Occupation: