Naperville Eye Associates
1855 Bay Scott Circle
Naperville, IL 60540
630-357-5280

To our newest patient,

Thank you so much for scheduling your appointment with Naperville Eye Associates!

Please read the following before coming in for your appointment:

- Complete the forms attached and bring them with you to your appointment.
- Have your insurance card(s) and driver's license or ID available upon arrival.
- Patients with insurance will be required to pay a specialist copay (this can be found on the front of your insurance card) and may be subject to a $40 refraction fee.
- Self-pay patients will be required to pay for all services rendered at the end of their appointment.
- If you have medical records for the doctor, please bring them with you or have them faxed to 630-357-5367 by your doctor before your appointment.
- Referrals are required for all HMO insurance policies. Please ensure you have an active referral from your primary care physician before arriving for your appointment.
- A $50.00 fee will be incurred for cancellations made less than 24 hours in advance.
- If you should have any questions or trouble finding our office, please give us a call. We are in office Monday – Thursday 8am-5pm and Friday 8am-12pm.

We look forward to seeing you soon!

All the best,
Naperville Eye Associates 😊

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Naperville, IL 60540

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Patient Name:_____ Local Pharmacy: _____

Home Address:_____ Apt/Unit:_____
Street

_____
City State Zip

Home Number:_____ Cell number:_____

Date of Birth:____/____/_____ SSN:_____-_____-_____

Primary Care Doctor:_____ Referring Doctor:_____

Please circle one: Sex: Male Female Marital Status: Single Married Widowed Divorced

Patient Employer:_____ _____ Employer Phone:_____

Please Circle one: Full-time Part-time Self-employed Retired Not employed

Employer address:_____
Street City State Zip

Responsible Party (Parents and/or Guardian)/Workman's Compensation Information Only

Name:_____ SSN:_____

Relationship to patient_____ Date of birth:____/____/_____

Billing Address:_____
Street City State Zip

Employer Address:_____
Street City State Zip

Employer Number:_____

I hereby authorize Naperville Eye Associates to release any and all medical information to my given insurance/healthcare provider (or to designated attorney for purposes of claims administration and evaluation, utilization review, and financial audit.) This authorization remains valid and effective from the date of signing until revoked in writing. I understand that I may request a copy of this authorization. I have read this authorization and understand it. I hereby assign Naperville Eye Associates all money to which I am entitled for medical and/or surgical expense relative to the service rendered by Naperville Eye Associates, but not to exceed my indebtedness to said physician and/or surgeon. It is understood that any money received from my given insurance company over and above my indebtedness will be refunded to the insurance company when my bill is paid in full. I understand I am financially responsible. 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. Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns. I have read and understand the Financial Policy.

Patient Signature:_____ Date: _____

Responsible Party Signature:_____ Date: _____

PATIENT_____ DATE_____

ALLERGIES ☐None or List_____

MEDICATIONS	EYE MEDICATIONS	OCULAR HISTORY

FAMILY HISTORY

Glaucoma ☐ No ☐ Yes_____

Cataract ☐ No ☐ Yes_____

Strabismus (lazy eye)

☐ No ☐ Yes_____

Diabetes ☐ No ☐ Yes_____

Other _____

SOCIAL HISTORY

Married ☐ Yes ☐ No ☐ D ☐ W

Live Alone ☐ Yes ☐ No

Smoking Hist. ☐ Yes ☐ No

(ppd x yr) _____ Quit Yr_____

Drinking Hist. ☐ Yes ☐ No

(Drink/wk x yrs)_____Quit Yr_____

Occupation_____

PAST HISTORY

(Illnesses, Operations, Injuries, Treatments)

MEDICAL HISTORY (REVIEW OF SYSTEMS) If checked "Yes," please explain.

General Symptoms

Fever ☐ No ☐ Yes_____

Fatigue ☐ No ☐ Yes_____

Weight Loss ☐ No ☐ Yes_____

ENT

Hard of Hearing ☐ No ☐ Yes_____

Throat ☐ No ☐ Yes_____

Cardiovascular

Heart Disease ☐ No ☐ Yes_____

High Blood Pressure ☐ No ☐ Yes_____

Respiratory

Asthma ☐ No ☐ Yes_____

Emphysema ☐ No ☐ Yes_____

Intestinal

Ulcers ☐ No ☐ Yes_____

Bleeding ☐ No ☐ Yes_____

Urinary

Burning ☐ No ☐ Yes_____

Bleeding ☐ No ☐ Yes_____

Arthritis ☐ No ☐ Yes_____

Skin/Breast Cancer ☐ No ☐ Yes_____

Neurological

Headache ☐ No ☐ Yes_____

Double Vision ☐ No ☐ Yes_____

Psychiatric ☐ No ☐ Yes_____

Endocrine

Diabetes ☐ No ☐ Yes_____

Thyroid Disease ☐ No ☐ Yes_____

Blood Disease

AIDS/HIV ☐ No ☐ Yes_____

Bleeding Problems ☐ No ☐ Yes_____

Coumadin ☐ No ☐ Yes_____

Allergic/Immunologic _____

(Also see Drug Allergies above)

NAPERVILLE EYE ASSOCIATES FINANCIAL POLICY

Thank you for choosing Naperville Eye Associates as your healthcare provider. Our physicians and staff are committed to providing you and your family with quality ophthalmological care. To achieve these goals, we need your clear understanding of our financial policy. You are financially liable for the cost of services rendered.

INSURANCE PLANS: The physicians at Naperville Eye Associates participate with most major insurance and managed care plans. We do not participate with any vision insurance plans. We will bill your primary medical insurance. We only bill secondary insurance companies when Medicare is primary. To properly bill your insurance company, we require that you disclose all insurance information as well as any change in your insurance information. Failure to provide complete insurance information may result in you being responsible for the entire bill. Although we can estimate what your insurance company may pay, the insurance company makes the final determination of your eligibility and benefits. You will be responsible to pay any portion of the charges not covered by insurance. ALL COPAYS DUE AT TIME OF SERVICE!

HMO/REFERRAL CARE: You must obtain a referral authorization from your primary care physician prior to your appointment. We cannot book any appointments if we do not have your referral. If you do not have a valid authorization prior to your visit, your appointment will need to be rescheduled. If you choose to be seen without an authorization, you will be responsible for payment at the time of service.

UNINSURED PATIENTS: Full payment is due at time of service.

REFRACTION FEE: A refraction helps to evaluate the health and function of the eyes. Your doctor may need to perform a refraction to evaluate your eye condition. The refraction is typically NOT covered by most insurances and Medicare. You will be financially responsible for this charge.

CONTACT LENS FIT FEES: A contact lens evaluation, update of prescription, new fit, and refit are NOT included in a regular routine eye exam. There is an additional charge for this service that is determined by the doctor. Payment is due at time of service.

COLLECTION COSTS: Should you fail to reimburse Naperville Eye Associates for services rendered and your balance remains unpaid, your account will be sent to a third-party collection agency for pursual of payment. In the event an account is turned over for collections, the person financially responsible for the account will be responsible for all collections costs, including and not limited to reasonable legal and third-party fees. Outstanding balances must be resolved prior to scheduling any appointments.

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 $25 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.

MISSED APPOINTMENTS: If you are unable to keep your scheduled appointment, please notify us at least 24 hours in advance so we can accommodate our other patients. You may also reschedule at that time. The first time you miss an appointment without notifying our office, you will receive a phone call to remind you of the missed appointment and to reschedule you. For all other missed appointments, you will be billed a $50 no-show fee.

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.

I have read and understand the above financial policy of Naperville Eye Associates.

_____ _____

Signature of patient/parent or guardian Date

_____

Printed name of patient

SEE OVER: PAGE 1 OF 2

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I 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 your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

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.

Patient Name: _____

Grant Access to Family Member & Personal Representatives:

_____

Relationship to Patient:

_____

Emergency contact phone #

_____

Signature: Date:

Health Portal Email:

_____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason: