EYE SPECIALISTS OF ILLINOIS S C

P O BOX 577
PARK RIDGE, IL 60068-0577
USA
(847) 823-2127

PATIENT INFORMATION

NAME (Last, First Middle)		SSN	BIRTHDATE	SEX
LOCAL ADDRESS	CITY, STATE ZIP	REFERRING PHYSICIAN		ETHNICITY
HOME/DAY PHONE#		PRIMARY CARE PROVIDER		RACE

MARITAL STATUS	STUDENT STATUS ☐ Full-Time ☐ Part-Time	SMOKER (Y/N)?	VETERAN (Y/N)?	EMERGENCY CONTACT NAME	CONTACT PHONE

CELL#	EMAIL

PRIMARY EMPLOYER	SECONDARY EMPLOYER (If Applicable)
ADDRESS	ADDRESS
CITY, STATE ZIP	CITY, STATE ZIP
WORK PHONE	WORK PHONE

RESPONSIBLE PARTY INFORMATION (If Different than above)

NAME (Last, First Middle)		SSN#	BIRTHDATE	LANGUAGE	SEX
LOCAL ADDRESS	CITY, STATE ZIP		SECONDARY/BILLING ADDRESS (If Applicable)		
HOME PHONE	DAY PHONE	EMAIL ADDRESS	CITY, STATE ZIP		

MARITAL STATUS	STUDENT STATUS ☐ Full-time ☐ Part-time	SMOKER (Y/N)?	VETERAN (Y/N)?	PRIMARY CARE PROVIDER	HOME PHONE

RELATIONSHIP TO PATIENT	

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY		POLICY#	
NAME OF INSURED		GROUP#	
ADDRESS OF INSURANCE COMPANY		COPAY AMT	$
CITY, STATE ZIP	PHONE	DEDUCTIBLE	$
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (If Applicable)

NAME OF INSURANCE COMPANY			POLICY#
NAME OF INSURED	SSN#	BIRTHDATE	GROUP#
ADDRESS OF INSURANCE COMPANY			COPAY AMT $
CITY, STATE ZIP	PHONE		DEDUCTIBLE $
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE

I authorize the release of information to insurance carriers and/or other healthcare providers as may be necessary to file a claim or facilitate my health care. I ASSIGN PAYMENT OF BENEFITS TO EYE SPECIALISTS OF ILLINOIS, S.C. OR PROVIDER INDICATED ON THE CLAIM. I understand I am financially responsible for any balance not covered by my insurance carrier. A copy of this authorization is as valid as the original.

SIGNATURE OF PATIENT/GUARDIAN _____ DATE _____

MEDICATION LIST

Patient Name_____ Date_____

Allergies and What are the Reactions_____

_____

Do you have a pacemaker? _____

Please list all medications, vitamins, and herbal supplements

Medication including Over the Counter	Dosage Dosage Amount	Frequency How often used daily?

Have you ever had surgery or laser procedures on your eyes? If yes, please list procedures and dates._____

_____

_____

EYE SPECIALISTS of ILLINOIS

NAME_____ DATE_____ DR._____

REVIEW OF SYSTEM

PLEASE ANSWER THE FOLLOWING QUESTIONS, AS WE ARE CONCERNED ABOUT YOUR GENERAL HEALTH AS WELL AS THE FACT THAT PROBLEMS ELSEWHERE IN THE BODY MAY AFFECT YOUR OCULAR HEALTH AND VISION.

DO YOU HAVE ANY PROBLEMS WITH THE FOLLOWING SYSTEMS?
PLEASE CHECK THE CORRECT BOX YES OR NO.

SYSTEM	EXAMPLES	YES	NO
CONSTITUTIONAL	FEVER, FATIGUE, NIGHT SWEATS		
HEENT	PROBLEMS WITH EAR, NOSE OR THROAT		
RESPIRATORY	SHORTNESS OF BREATH OR COUGH		
CARDIOVASCULAR	CHEST PAIN OR PALPITATIONS		
VASCULAR	SWELLING OF ANKLES		
GASTROINTESTINAL	VOMITING, DIARRHEA OR CONSTIPATION		
GENITOURINARY	PROBLEMS URINATING, PAIN, DISCHARGE OR BLEEDING		
REPRODUCTIVE			
METOBOLIC/ ENDOCRINE	EXCESSIVE THIRST, HEAT OR COLD INTOLERANCE		
NEURO/PSYCHIATRIC	DIZZINESS, EMOTIONAL DISTURBANCES		
DERMATOLOGIC	SKIN DISEASE, ITCHING OR RASHES		
MUSCULOSKELETAL	BACK OR JOINT PAIN		
HEMATOLOGY	BRUISING OR BLEEDING		
IMMUNOLOGY	FOOD OR ENVIRONMENTAL ALLERGIES		

WHO REFERRED YOU TO OUR PRACTICE _____

PRIMARY CARE PHYSICIAN_____PHONE#_____

EMERGENCY CONTACT PERSON_____PHONE#_____

PHARMACY NAME_____PHONE#_____

ESI CAN LEAVE A MESSAGE OR MEDICAL INFORMATION ON THE FOLLOWING ANSWERING MACHINES OR VOICEMAIL: HOME ☐ WORK ☐ CELL ☐

ESI CAN ALSO LEAVE A MESSAGE OR MEDICAL INFORMATION WITH THE FOLLOWING PEOPLE:

NAME: _____PHONE# _____

RELATIONSHIP TO PATIENT: _____

NAME: _____PHONE# _____

RELATIONSHIP TO PATIENT: _____

DATE OF BIRTH_____ DOCTOR _____

EYE SPECIALISTS OF ILLINOIS, S.C.

Patient's Financial Policy

The objective of our Financial Policy is to clearly outline patient and practice financial responsibilities. We are committed to providing our patients with excellent care and to make matters related to the payment for health care services as straightforward as possible.

Eye Specialists of Illinois, S.C. participates with numerous insurance companies and managed care programs. Our Business office will submit claims for patients that are members of one of these plans.

1. It is your responsibility to provide us with accurate and current insurance information and to **Present Your Insurance Card at Each Visit.**
2. If your coverage is contingent on a referral, second opinion or a pre-admission authorization, it is your responsibility to inform us.
3. **It is also your responsibility to provide our Practice with the required referral form(s) prior to the visit.** Without a referral, visits may be rescheduled, or you will be financially responsible for payment at time of service.
4. **Co-payments are expected at the time of service.**
5. The refraction fee is not a covered benefit under **MEDICARE AND most insurances; the $50.00 refraction fee is due at the time of service.**
6. Deductibles may be collected prior to surgical procedures.
7. Payment for services can be made with cash, check, or credit card. We accept Visa, MasterCard and Discover. In an event that a check is returned for insufficient funds there will be a fee of $25.00.
8. If you do not have insurance, you are expected to pay for professional services at the time of service.
9. In the event the bill has not been paid, information that is helpful and /or necessary for collection purposes will be forwarded to a professional collection agency.

Our staff is happy to help with any questions regarding our Financial Policy, your account, claims, or other questions you may have about your bill. Specific questions about coverage issues can only be addressed by your insurance company. We are here to help you.

Please sign that you have read and agree to this Financial Policy.

X Signature _____ Date _____

Signature of Patient/Responsible Party

(Print Name) _____

Signature _____ Date _____

Signature of Eye Specialists Representative

10/2019 ESI

Eye Specialists of Illinois, S.C.

444 N. Northwest Highway
Park Ridge, Illinois 60068
Telephone 847.823.2127
Facsimile 847.823.0641

PATIENT ASSIGNMENT OF BENEFITS
AND
RECEIPT OF PRIVACY NOTICE

MANAGED CARE PATIENTS

I am aware of all restrictions and guidelines enforced by my insurance plan.
I understand each service must be pre-authorized and that obtaining the authorization is my responsibility.
Without proper authorization, I understand that payment may be required at the time of service.
Patient Initials_____

ASSIGNMENT OF BENEFITS

I hereby assign payment of benefits to EYE SPECIALISTS OF ILLINOIS, S.C. OR ITS PROVIDERS. I understand I am financially responsible for any balance not paid by my insurance carrier.

X_____ _____

Signature of Patient or Legal Guardian Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY POLICIES

I understand that EYE SPECIALISTS OF ILLINOIS, S.C. originates and maintains protected health information for the purposes of Treatment, Payment and Healthcare Operations.

I acknowledge receipt of EYE SPECIALISTS OF ILLINOIS, S.C.'s Notice of Privacy Practices (NPP). My signature below also indicates my consent for the Use and Disclosure of my protected health information as outlined in the notice. It further allows for the release of my information for the purpose of carrying out treatment, payment, healthcare operations, and law enforcement.

I understand that since EYE SPECIALISTS OF ILLINOIS, S.C. has the right to change their Privacy Practice in accordance with the Law; the terms contained in the Notice may change as well. EYE SPECIALISTS OF ILLINOIS, S.C. will provide a copy of the most updated Notice in the reception area of the office. A copy of the notice will also be provided upon request.

I may revoke this consent provided that I do so in writing, except to the extent that EYE SPECIALISTS OF ILLINOIS, S.C. has already use/disclosed the information relied upon by this consent.

X_____ _____

Signature of Patient Date

_____ _____

Signature of Authorized Representative Date

EYE SPECIALISTS of ILLINOIS

Welcome to Eye Specialists of Illinois

BRUCE H. KAPLAN, M.D.
Ophthalmology
Glaucoma
Diseases of the Eye

JOHN J. MOY, M.D.
Ophthalmology
Refractive Surgery/LASIK
Cornea/External Disease
Cataract Surgery

NOEL D. SAKS, M.D.
Ophthalmology
Ophthalmic Plastic & Reconstructive Surgery
Orbital Surgery

KYLA TERAMOTO HARA, M.D.
Ophthalmology
Glaucoma
Cataract Surgery

INDRE RUDAITIS, O.D.
Optometry
General Eye Exams
Contact Lens

RIDGE OPTICAL SHOP
Contact Lens
Glasses

- Please bring your current insurance card and photo ID.
- Co-Pays are required at check-in.
- Please bring your most recent pair of glasses, and please complete the enclosed medication list form.
- If you have an HMO, you are responsible for obtaining and bringing a referral form to your appointment.
- Dilated exams may take up to 2 hours or more. Please plan your day accordingly. Disposable sunglasses will be provided.
- Please have your pharmacy name and phone number.
- Refractions are not covered by Medicare and most insurances. Please be prepared to pay $50 at the time of service; please see the attached "What is a Refraction" form.
- We are required to obtain your race, language preference, and ethnicity.

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Telephone: 847.832.2127 • Fax: 847.823.0641

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WHAT IS A REFRACTION?

THE REFRACTION TEST PROVIDES THE DOCTOR WITH IMPORTANT INFORMATION ABOUT YOUR VISION AND THE HEALTH OF YOUR EYES.

1) THE REFRACTION IS A TEST PERFORMED TO DETERMINE AN EYE'S REFRACTIVE ERROR AND TO PROVIDE THE CLEAREST VISION.

2) IT AIDS THE DOCTOR IN PRESCRIBING YOUR NEW GLASSES; WITHOUT THIS TEST WE CANNOT DETERMINE IF YOU NEED A CHANGE IN YOUR EYEGLASS PRESCRIPTION.

3) OF IMPORTANCE IS THAT THE REFRACTION TEST ALSO PROVIDES THE DOCTOR WITH NECESSARY INFORMATION WHEN EVALUATING FOR EYE DISEASES SUCH AS CATARACTS, GLAUCOMA, RETINAL PROBLEMS, CORNEAL DISEASE, AND MORE.

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