Medical Eye Services

PATIENT REGISTRATION

Patient: _____ _____ _____ _____ _____
Last Name First Name M.I. Date of Birth Age

Address: _____ _____ _____ _____
Street City State Postal Code

Social Security #: _____ E-Mail: _____

Phone: Home: _____ Cell: _____ Work: _____

Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Primary Care Physician: _____ _____ _____
Last Name First Name M.I.

Address: _____ _____ _____ _____
Street City State Postal Code

Office Phone: _____ Fax: _____

Insurance Cardholder or Legal Guardians' Information

Last Name: _____ First Name: _____ M.I. _____

Social Security#: _____ Gender _____ Date of Birth: _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to Medical Eye Services all insurance benefits, if any otherwise payable to me for services rendered.

- I understand that I am financially responsible for all charges whether or not paid by insurance.
- I hereby authorize the doctor or their agent to release all information necessary to secure the payment of benefits.
- I authorize the use of this signature on all insurance submissions.

I have read and understand this statement: _____ _____
Patient/Parent Signature (Parent for Minor) Date

REFRACTION SERVICE AND FEE

Refraction is the test that is performed to determine your eyeglass or contact lens prescription. The refraction is an essential part of a complete eye exam. Many insurance plans do **NOT** cover the refraction and require that we charge separately for that portion of the exam. Our office fee for the refraction portion is **$50.00**, and this fee is collected at the time of service in addition to any co-payment your plan may require. If your plan does pay for the refraction, we will reimburse you.

Patient Acknowledgment: I have read the above information and

☐ **Agree** to be refracted for an updated prescription.

☐ **Decline** to be refracted for an updated prescription.

FINANCIAL & BILLING POLICY

If you have any questions regarding this financial/billing policy please do not hesitate to contact our billing department at (847)662-4016

By signing, I have read and understand the financial/billing policy of Medical Eye Services.

_____

Printed name of patient:

_____

Signature of patient or legal guardian:

_____

Date

Medical Eye Services

Consent for Medical Procedures/Disclose Medical Information

I, _____ give permission to the following people, power to consent for medical procedures and all treatment including any test results on my behalf including any medical information, financial information and any other information related to my visit with Medical Eye Services, Ltd.

Name	Relationship to Patient	Date
Name	Relationship to Patient	Date
Name	Relationship to Patient	Date
Name	Relationship to Patient	Date

_____ _____

(Patient Signature) (Date)

Medical Eye Services

MEDICATION RECONCILIATION LIST

PATIENT: _____ **DATE:** _____

MEDICINE NAME	DOSAGE	HOW OFTEN

www.medeye.net

48 S. Greenleaf Street
Gurnee, IL 60031
847-662-4016

900 N. Westmoreland, Suite LL-74
Lake Forest, IL 60045
847-735-0500

Medical Eye Services

FINANCIAL & BILLING POLICY

Thank you for choosing Medical Eye Services to serve your healthcare needs. We provide the best possible care for you and we want you to fully understand our financial and billing policy. We look forward to building a lasting relationship as your healthcare provider.

INSURANCE- We are a participating provider with many Medical Insurance Plans, however, we do not take Vision Plans. As a courtesy to you, we will bill your insurance company directly for medical services rendered. Prior to your visit, our office will verify your benefits, ultimately it is patient's responsibility to check with your insurance for any co-pays, co-insurance, deductible, out of network, usual and customary limit, pre-authorization requirements or any other type of benefit limitation for services you might owe. Take in consideration that confirmation of benefits it is not a guarantee of payment. Payment is expected at the time of your visit.

If your insurance changed please notify our staff immediately and provide us your new Member Identification Card. On the contrary it could result in billing incorrectly holding you responsible for the full balance.

If you have primary coverage with Medicare please provide your Medicare or Medicare replacement card along with any additional medical coverage you may have. Billing to the incorrect insurance will result in insurance denying or not processing the claim making you responsible for services rendered.

If you have primary coverage with a Commercial Plan and secondary coverage with Medicaid, please note that we do not accept Medicaid in this instance and any balance or amount unpaid by the primary carrier will be patient's or patient's guarantor responsibility.

SELF PAY PATIENTS-Self pay patients are patients that have no insurance for our office to bill. As a courtesy, our office can extend a 10% discount of our fees. Payment in full is expected at the time of visit.

REFERRALS-All HMO plans require you to obtain authorization for services from your primary care provider. It is your responsibility to obtain this referral before you schedule an appointment. It is patient's responsibility to make sure such referral is valid and up to date. Failure to do so could result in Insurance denying services provided to you, holding you responsible for services rendered but not approved by your insurance.

OPTICAL GOODS- A 50% deposit is required at the time of order and the balance must be paid in full at the time of delivery for all contact lenses, contact lens supplies, glasses, and optical accessories.

COLLECTION ACCOUNTS-If a patient fails to pay their account balance after 90 days, a patients' account will be sent to an outside collection agency. If your account goes to collection it will be necessary for you to pay the account in full before receiving any further care.

RECORD COPY FEES – There is a fee for anyone requesting their medical records. Our office fee schedule for copy fees goes along with the State of Illinois Record Copy Fee Guidelines. These fees change every year. We will inform you of the fee before we copy your records.