Medical Eye Services

Howard H. Tessler, M.D.
General Ophthalmology
Uveitis
External Disease
Cornea

Nancy A. Hamming, M.D.
Pediatric Ophthalmology
& Strabismus

Daniel J. Green, M.D., Ph.D.
General Ophthalmology
Glaucoma

Rachael A. Greenberg, M.D.
General Ophthalmology
Cataract and Laser Surgery

Lisa S. Thompson, M.D.
Pediatric Ophthalmology
& Adult Strabismus

Dear patient,

We appreciate your selection of our office for your eye care.

In this packet you will find the following forms that need to be completed in advance of your appointment:

- Patient Registration
- Refraction Service and Fee
- Phone/Email Contact
- Financial Policy
- Billing Policy
- Consent for Medical Care of a Minor
- HIPAA Policy
- Consent to Disclose Patient Medical Information
- Adult Medical History Questionnaire
- Pediatric Medical History Questionnaire

Initial visits usually take approximately one and a half hours. We ask that you please bring the following items to your appointment:

- List of medications you are currently using.
- Insurance card
- Drivers License or other State or Federal form for identification purposes.

If your insurance plan requires you to have a referral for this visit, please check with your primary care physician for the referral prior to this visit. Co-pays are collected at the time of service. If for any reason you are unable to keep this appointment please call our office to reschedule.

Sincerely yours,

The doctors and staff of Medical Eye Services

Medical Eye Services

PATIENT REGISTRATION

PATIENT INFORMATION (Please Print)

Patient: _____ _____ _____ _____
Last Name First Name 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

If patient is a minor, who is responsible for the bill: _____

Primary Care Physician: _____ _____
Last Name First Name

Address: _____ _____ _____ _____
Street City State Postal Code

Office Phone: _____

Referring Physician If Different From Above: _____ _____
Last Name First Name

Address: _____ _____ _____ _____
Street City State Postal Code

Office Phone: _____

EMPLOYMENT INFORMATION OF PATIENT (OR INSURANCE CARDHOLDER) (Please Print)

Last Name: _____ First Name:_____

Social Security#: _____ Date of Birth: _____

Employer: _____ Occupation: _____

Employer Address: _____ _____ _____ _____
Street City State Postal Code

Phone: _____Extension: _____

REFRACTION SERVICE AND FEE

A refraction is a test that checks the vision for improvement with glasses or contact lenses and is included in all routine examinations. It is an essential part of an eye examination and necessary to write a prescription for glasses or contact lenses. **YOU MUST NOTIFY THE DOCTOR'S ASSISTANT IF YOU DO NOT WANT THE REFRACTION PERFORMED DURING YOUR EXAMINATION.**

- **Some medical insurance plans, including Medicare, do NOT cover the cost of a refraction which is $40.**
- **You will be required to pay $40.00 if Medicare is your primary insurance.**
- **We will submit the cost to your insurance plan and if they do not pay for it then we will send a bill to you for the cost.**

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

TURN OVER AND COMPLETE OTHER SIDE

Medical Eye Services

PATIENT REGISTRATION
Continued

INSURANCE INFORMATION

Primary Insurance Company: _____

Type of Primary Insurance: ☐ MEDICARE ☐ MEDICAID ☐ HMO ☐ POS ☐PPO

Our office participates with a variety of insurance plans. **It is your responsibility to:**

- **Bring your insurance card(s) at every visit.**
- **Be prepared to pay your co-pay at each visit. Payment can be made by cash, check or credit card.**
- **For eye care not covered by your insurance, payment is due at the time of service.**

Our practice firmly believes that a good physician/patient relationship is based upon understanding and communication.

- If you have any questions about your insurance please call the member services number listed on your insurance card **prior** to your visit to confirm your benefits coverage. Most insurance companies such as Blue Cross/Blue Shield do not pay for non-medical examinations or examinations for glasses.
- If you have insurance that we do not participate in our office is happy to file the claim upon request, however, **payment is due at the time of service.**
- It is your responsibility to bring any required referrals for treatment at, or prior to the visit. If you do not have the referral, your visit may be rescheduled, or may have financial responsibility.
- If the patient is a minor (17 years and younger), the parent or guardian or unaccompanied minor is responsible for any payments due at the time of service, bringing the necessary referrals and insurance card(s).

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

Medical Eye Services

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

REFRACTION SERVICE AND FEE

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Some medical insurance plans, including Medicare, do NOT cover the cost of a refraction which is $40.00 We will submit the cost to your insurance plan and if they do not pay for it then we will send a bill to you for the cost.

Patient Acknowledgement

I have read and understand this statement:

_____ _____

Patient Signature (Parent for Minor) Date

09/22/10

Medical Eye Services

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

Phone/Email Contact Policy

I authorize my health care provider to use an automated telephone system and/or email and to use my name, address and phone number; the name of my scheduled treating physician; and the time and place of my scheduled appointment(s) for the limited purpose of contacting me to notify me of a pending appointment and/or other health care related communication.

I also authorize my healthcare provider to disclose to third parties who answer my phone limited protected health information regarding pending appointments, and to leave a reminder message on my voice mail system or answering machine.

I also authorize the office staff and/or physician to call me at this number.

Phone Number_____

Email:_____

Signature _____Date_____

Print Name_____

Medical Eye Services

FINANCIAL POLICY

The following information is provided to avoid any misunderstandings or disagreement concerning payment for professional services. We are committed to providing you with the best possible eye care. If you have special needs, we are here to work with you.

Our office participates with a variety of insurance plans. **It is your responsibility to:**

- Bring your insurance card(s) at every visit.
- Be prepared to pay your co-pay at each visit. Payment can be made by cash, check or credit card.
- For eye care not covered by your insurance, **payment is due at the time of service.**

In Addition:

- If you have insurance that we do not participate in our office is happy to file the claim upon request; however, **payment in full is expected at the time of service.**
- If you are unable to pay for necessary care, you may be eligible for financial assistance. It is your responsibility to inform us prior to the visit.
- It is your responsibility to bring any required referrals for treatment at, or prior to the visit. If you do not have the referral, your visit may be rescheduled, or may have financial responsibility.
- If the patient is a minor (18 years and younger), the parent or guardian or unaccompanied minor is responsible for any payments due at the time of service, bringing the necessary referrals and insurance card(s).
- If you have any questions about your insurance, we are happy to help you. Specific coverage issues, however, should be directed to your insurance company member services department (the number is on your insurance card).

Our practice firmly believes that a good physician/patient relationship is based upon understanding and communication. Questions about financial arrangements should be directed to our office. Please sign that you have read and agree to this financial policy.

_____ _____

Signature of Patient of Responsible Party Date

4/2009

Medical Eye Services

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

BILLING POLICIES

The best medical care can be provided only on the basis of mutual understanding. We encourage you to discuss any questions you may have regarding our policies with our billing staff.

Insurance

We participate in a variety of insurance plans and will directly bill your insurance under these plans. In this circumstance you are responsible only for applicable co-payments before the visit. If you have not met your deductible, you may pay at the time of your visit or we will bill you after we receive a response from your insurance company. We cannot accept responsibility for negotiating claims with insurance companies. You are responsible for payment of your medical care within a reasonable time, regardless of status of a claim. Services not covered by your insurance are your responsibility.

Co-payments

When your insurance specifies a co-payment (usually indicated on the identification card), this payment must be made at check-in, prior to your exam.

Prior Authorization and Vision Care Forms

Some health maintenance organization (HMO) plans require you to obtain authorization for services from your primary care provider (internist, family practitioner, pediatrician, etc.). It is your responsibility to obtain authorization from your primary care provider. This is required by your insurance before you visit our office, even when the visit is for an urgent problem. Contact your insurer if you have questions, or contact the office of your primary care provider. Some insurance companies require you to obtain a form or voucher prior to your eye exam. This can be obtained by calling your insurer directly.

We Participate with Medicare

We are participating providers under Medicare. This means we accept the fees set by Medicare for medical services covered by the Medicare program, including surgery. Medicare patients will be responsible only for co-payments, deductibles and non-covered services, such as refractions and routine eye exams.

Optical Goods

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

Credit Cards

For your convenience, we accept Visa, MasterCard, American Express, and Discover.

Billing

If billing is necessary, a statement will be mailed to you which is due within 30 days. Charges and payments for services received during the last few days before your billing date may appear on the following month's statement.

Insurance Counseling

Before any surgical procedure or exam which may entail greater expense, our office will provide insurance coverage information and estimate what, if any, balance may remain once insurance has paid. At your request, we will provide information on coverage to the best of our ability for any examination or procedure we perform, even when not of great expense. If special financial circumstances warrant an extended payment plan, our staff will be glad to help you.

For answers to further questions, please contact our billing department at 847-662-1298

Medical Eye Services
48 S. Greenleaf Avenue
Gurnee, IL 60031
847-662-4016

CONSENT FOR MEDICAL CARE OF A MINOR

Patient Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Birthdate: _____

Home Telephone: _____

Cellular Telephone: _____

I authorize the following people to bring my son/daughter to be seen by his/her ophthalmologist and sign any and all necessary documentation for the exam.

(1)_____
(2)_____
(3)_____

I understand that this authorization shall be valid for one (1) year unless otherwise stated below or revoked through written notice to Medical Records.

Signature of Parent/Guardian: _____

Date: _____

Medical Eye Services

NOTICE OF PRIVACY PRACTICES

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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, to be kept confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.

- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

- **Health care operations** include the business aspects of running our practice, such as conducting quality -assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be art internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

- The right to inspect and copy your protected health information.

- The right to amend your protected health information.

- The right to receive an accounting of disclosures of protected health information.

- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of July 1, 2010 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint. Please contact our Compliance Officer for more information.

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 819-0257
Toll Free: 1-877-696-6775

Medical Eye Services

CONSENT TO DISCLOSE PATIENT MEDICAL INFORMATION

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

Name	Relationship to Patient	Phone Number
Name	Relationship to Patient	Phone Number
Name	Relationship to Patient	Phone Number
Name	Relationship to Patient	Phone Number
Name	Relationship to Patient	Phone Number

_____ _____

Patient Signature Date

Medical Eye Services

48 S. Greenleaf Avenue
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847-662-4016

Adult Medical History Questionnaire

Name:_____ Birth Date:_____

Name of physician referring you:_____ Physician Phone:_____

Physician Address:_____ Date of last eye exam:_____

REVIEW OF SYSTEMS
Do you currently have any problems in the following areas? If "yes", provide information.

	YES	NO	EXPLANATION OF PROBLEM
Constitutional Symptoms			
Fever	☐	☐	_____
Weight loss	☐	☐	_____
Other	☐	☐	
Eyes			
Loss of vision	☐	☐	_____
Blurred vision	☐	☐	_____
Distorted vision (halos)	☐	☐	_____
Loss of side vision	☐	☐	_____
Double vision	☐	☐	_____
Dryness	☐	☐	_____
Mucous discharge	☐	☐	_____
Redness	☐	☐	_____
Sandy or gritty feeling	☐	☐	_____
Itching	☐	☐	_____
Burning	☐	☐	_____
Foreign body sensation	☐	☐	_____
Excess tearing/watering	☐	☐	_____
Occasional tearing	☐	☐	_____
Glare/Light sensitivity	☐	☐	_____
Eye pain or soreness	☐	☐	_____
Chronic infection of eye or lid	☐	☐	_____
Sties, Chalazion	☐	☐	_____
Fluctuating visual acuity	☐	☐	_____
Tired eyes	☐	☐	
Ears, nose, mouth, throat			
Sinus congestion	☐	☐	_____
Runny nose	☐	☐	_____
Post-nasal drip	☐	☐	_____
Chronic cough	☐	☐	_____
Dry throat/mouth	☐	☐	_____
Respiratory (lungs/breathing)	☐	☐	_____
Chronic bronchitis	☐	☐	_____

Cardiovascular (heart/blood vessels)	☐	☐	
Gastrointestinal (stomach/intestines)	☐	☐	
Genitourináry (genitals/kidney/bladder)	☐	☐	
Musculoskeletal			
Joint pain	☐	☐	
Integumentary (skin and/or breast)	☐	☐	
Neurological	☐	☐	
Psychiatric	☐	☐	
Endocrine	☐	☐	
Hematologic/Lymphatic			
Blood	☐	☐	
Lymph nodes	☐	☐	
Swelling	☐	☐	
Allergic/Immunologic	☐	☐	
Head allergy symptoms	☐	☐	
PsychiatrIc	☐	☐	

PAST HISTORY

List any medications you take:

List all major illnesses and injuries:

List any surgeries you have had:

Have you had crossed eyes, lazy eye, drooping eyelid, prominent eyes?

	YES	NO
Do you have allergies to any medications?	☐	☐

If YES, list medications:

FAMILY HISTORY

	YES	NO	EXPLANATION OF PROBLEM
DISEASE			
Blindness	☐	☐	
Cataract	☐	☐	

FAMILY HISTORY-Continued

Glaucoma	☐	☐	_____
Macular degeneration	☐	☐	_____
Retinal detachment	☐	☐	_____
Arthritis	☐	☐	_____
Cancer .	☐	☐	_____
Diabetes	☐	☐	_____
Heart attacks	☐	☐	_____
High blood pressure	☐	☐	_____
Kidneydisease	☐	☐	_____
Lupus	☐	☐	_____
Sjogrens Syndrome	☐	☐	_____
Stroke	☐	☐	_____
Thyroid disease	☐	☐	_____
Tuberculosis	☐	☐	_____
Other	☐	☐	_____

SOCIAL HISTORY

Current occupation:

_____

Do you drive?	☐	☐
Do you have visual difficulty when driving?	☐	☐
Do you have problems with night vision?	☐	☐
Have you ever tried to wear contacts?	☐	☐
Do you currently wear glasses?	☐	☐
If YES, how long have you had the current pair?	☐	☐
Do you drink alcohol?	☐	☐
If YES, how many glasses a day	_____	
Do you smoke?	☐	☐
if YES, how many packs a day	_____	
Have you ever had a blood transfusion?	☐	☐
Have you ever been in intimate contact with a person who had a sexually transmitted disease?	☐	☐

Patient Signature: _____ Date:_____

History Reviewed: ☐ No changes ☐ Additions as noted above

Physician Signature: _____ Date:_____

Medical Eye Services

Pediatric Medical History Questionnaire

Child's Name:_____ Birth Date:_____

Date of last eye exam: _____ By what name does your child like to be called: _____

Pediatrician or Family Doctor: _____

REFERRING PHYSICIAN

Name of Physician Referring you: _____
Referring Physician Street Address: _____
City: _____
State: _____
Postal Code: _____
Telephone Number: _____

Chief Complaint or Reason for Visit:

_____

BIRTH HISTORY

	YES	NO
Was your child born prematurely?	☐	☐

If yes, what was your child's birth weight? _____
Gestational age: _____
Length of hospital stay: _____
Complications: _____

DEVELOPMENT HISTORY

Began to walk at what age? _____
Began to talk at what age? _____
Any delays? _____

SOCIAL HISTORY

Name of school: _____
Grade in school: _____

	YES	NO
Any problems with distance vision?	☐	☐
Any problems with reading?	☐	☐
Has your child been diagnosed with ADD or ADHD?	☐	☐
Does your child have any learning disabilities:	☐	☐

If yes, please explain:

_____

MEDICAL HISTORY

What medical problems has your child had?

_____

	YES	NO
Has your child been hospitalized?	☐	☐

If yes, what dates and reason? _____

SURGICAL HISTORY

	YES	NO
Has your child ever had surgery?	☐	☐

If yes, what dates? _____

For what procedures:

_____

ALLERGY HISTORY

List any allergies your child may have: _____

MEDICATION HISTORY

List any medications your child is taking including the dose: _____

FAMILY HISTORY

Is there any family history of:	YES	NO
Amblyopia (lazy eye)	☐	☐
Strabismus (crossed or wandering eye)	☐	☐
Cataracts	☐	☐
Glaucoma	☐	☐
Diabetes	☐	☐
Other eye disease.	☐	☐

Is there any other information you would like to share with us about your child?

_____

REVIEW OF SYSTEMS

Do you currently have any problems in the following areas? If "yes", provide information.

	YES	NO	
Ears, nose, mouth, throat	☐	☐	_____
Respiratory (lungs/breathing)	☐	☐	_____
Cardiovascular (heart/blood vessels)	☐	☐	_____
Gastrointestinal (stomach/intestines)	☐	☐	_____
Genitourináry (genitals/kidney/bladder)	☐	☐	_____
Musculoskeletal	☐	☐	_____
Integumentary (skin and/or breast)	☐	☐	_____
Neurological	☐	☐	_____
Psychiatric	☐	☐	_____
Endocrine	☐	☐	_____
Hematologic/Lymphatic/Blood	☐	☐	_____
Allergic/Immunologic	☐	☐	_____

Parent/Guardian Signature: _____Date:_____

Update:_____ Date: _____

Update: _____ Date: _____

Physician Signature: _____ Date: _____