MEDICAL EYE SERVICES, LTD.

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 &
Laser Surgery

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

Dear Patient

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

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

- Insurance Card.
- Driver's License or other State or Federal form for identification purposes.
- List of the medications you are currently using.

In addition, you will need to complete the enclosed forms and bring them with you to your appointment:

- Patient Registration/Refraction Service and Fee
- Financial & Billing Policy
- Consent to Disclose Patient Medical Information
- Consent for Medical Care of a Minor – if applicable
- HIPAA Confidentiality Policy
- Adult Medical History Questionnaire
- Pediatric Medical History Questionnaire – if applicable

If your **insurance plan requires a referral for this visit, please notify your primary care physician. You must have the referral with you at the time of your appointment.**

Your co-pay and coinsurance must be paid at the time of your appointment.

If for any reason you are unable to keep this appointment, please call our office to reschedule within 24 hours of your appointment.

48 S. Greenleaf Avenue
Gurnee, IL 60031
Phone (847) 662-4016
Fax (847) 662-6982

900 North Westmoreland
Suite #LL 74
Lake Forest, IL 60045
Phone (847) 735-0500
Fax (847) 735-1799

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#: _____ 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 process of determining if there is a need for glasses or contact lenses. Refraction is an essential part of a complete eye exam. Many insurance plans do NOT cover refractions 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. If you have any questions regarding insurance, please do not hesitate to ask. We will do our best to assist 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:

_____

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.

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)	☐	☐	_____
Genitourinary (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: _____

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Gurnee, IL 60031
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)	☐	☐	
Genitourinary (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

DISEASE	YES	NO	EXPLANATION OF PROBLEM
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:_____