CHICAGOLAND EYE CONSULTANTS

PATIENT REGISTRATION FORM

PHONE: 773.775.9755 | FAX: 773.775.4306 | CHICAGO-EYE.COM

Name: **Sex:** ❑M | ❑F **Age:** **Birth Date:** **Marital Status:**

Address: City: State: ZIP: Preferred Language:

Email: Phone » home: work: cell:

Race/Ethnicity: ❑ Hispanic ❑ American Indian or Alaskan Native ❑ Asian ❑ Black or African American ❑ Pacific Islander ❑ Caucasian ❑ Unknown

Patient SSN (optional)**:** **Referred by:** ❑ Friend/Family ❑ Dr. _____ ❑ Internet ❑ Other

Family Doctor: Phone:

Address: City: State: ZIP:

Parent Name (if minor): Parent SSN:

Bill to: Relationship to patient:

Address: City: State: ZIP:

Check one: ❑ HMO ❑ PPO ❑ Workman's Comp ❑ Private Insurance ❑ Patient Pay ❑ Medicare

Primary Insurance: Subscriber's Name: Relationship to Patient:

Policy #: Subscriber's ID#: Subscribers D.O.B.: / /

Secondary Insurance: Subscriber's Name: Relationship to Patient:

Policy #: Subscriber's ID#: Subscribers D.O.B.: / /

Employment: ❑ Occupation ❑ Retired ❑ Student

Employer: Supervisor Name: Phone: Ext:

Address: City: State: ZIP:

Emergency Contact: Phone: Relationship:

How did you hear about our clinic?:

MEDICAL HISTORY

CONDITION	YOU Yes / No	PARENT/SIBLING Yes / No
Prostate	❑ ❑	❑ ❑
Diabetes (onset: _____)	❑ ❑	❑ ❑
High Blood Pressure	❑ ❑	❑ ❑
Heart Disease / Heart Attack	❑ ❑	❑ ❑
Stroke	❑ ❑	❑ ❑
Arthritis	❑ ❑	❑ ❑
Thyroid Condition	❑ ❑	❑ ❑
Asthma / Emphysema	❑ ❑	❑ ❑
Aspirin / Blood Thinner	❑ ❑	❑ ❑
Currently Pregnant / Breast Feeding	❑ ❑	❑ ❑
Smoke / Drink	❑ ❑	❑ ❑
Communicable Disease	❑ ❑	❑ ❑
Cancer / Chemotherapy	❑ ❑	❑ ❑
HIV / AIDS	❑ ❑	❑ ❑
Hearing Difficulties	❑ ❑	❑ ❑
Renal Disease	❑ ❑	❑ ❑
Renal Dialysis Frequency:		
Other Respiratory Dx:		

OCULAR MEDICAL HISTORY

Glaucoma (onset:)	❑ ❑	❑ ❑
Cataracts	❑ ❑	❑ ❑
Macular Degeneration	❑ ❑	❑ ❑
Retinal Detachment	❑ ❑	❑ ❑
Lazy Eye / Eye Turn	❑ ❑	❑ ❑
Night Vision Problems	❑ ❑	❑ ❑
Eyeglasses	❑ ❑	❑ ❑
Contact Lenses	❑ ❑	❑ ❑
Refractive Surgery	❑ ❑	❑ ❑

ADDITIONAL INFORMATION

Major Surgeries:

Ocular Surgeries:

Medications:

Allergies:

Your Pharmacy:

Address

City State ZIP

Phone

How interested are you in having any non-surgical cosmetic treatment, such as Latisse, Botox or Juvederm? ❑ Very Interested ❑ Somewhat Interested ❑ Not Interested

Preferred Contact Method: ❑ Home ❑ Work ❑ Cell ❑ Email

I believe that all the information is true and complete to the best of my knowledge and I give CEC permission to view my medication history:

Patient (or parent) signature:

Medical History Updated (for completion by office personnel only)

Date: _____ Initials: _____ | Date: _____ Initials: _____ | Date: _____ Initials: _____

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President
Chief Medical Officer

FRANK P. LA FRANCO, M.D.
Retina

7447 West Talcott Ave., Suite 406
Chicago, IL 60631-3275

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Elgin, IL 60123-5523

773-775-9755

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Our Financial Policy

Thank you for choosing us as your eye care provider. We are committed to providing you with the highest quality of ophthalmologic care. Payment for the medical services rendered is an integral part of the financial support of our Practice. We require that you read and sign this form prior to any treatment.

Medicare and Commercial Insurance Patients: You must bring your insurance identification card on the day of your examination and present this card to the receptionist at the time of registration. **You are responsible for any co-payments and/or annual deductibles at the time of service.** As a courtesy, we will file with your supplemental insurance. In the event you do not have additional insurance, you will be responsible for the total balance due.

HMO Patients **All HMO patients MUST have a written referral or verbal authorization from their primary care physician on the day of the examination.** Please present the referral to our receptionist at the time of registration. **It is your sole responsibility to obtain any and all referrals.** If you do not have your referral, your appointment will be rescheduled or you will be required to make full payment on the day of your examination.

Worker's Compensation We **require written approval/authorization** by your employer and/or worker's compensation carrier **prior** to your initial visit. **If your claim is denied, you will be responsible for payment in full.**

Uninsured Patients
Full payment is due at the time of service.

Eye Refractions: **Most insurance companies do not pay for eye refractions.** This test is necessary to determine if an eyeglass prescription will improve your ability to see.
*I am aware that the charge for a refraction is $55.00 and is payable on the day of my examination. I will receive a prescription card with my current glass prescription.
*If you elect to purchase glasses at our Optical Boutique, we will waive the $55.00 charge for the refraction.
*This test may be required by the doctor for diagnostic purposes, and in that case, you will not be charged for this test. You will not receive a prescription card for eyeglasses.

*** A 50% deposit is required on all contact lens and eyeglass orders. The remaining 50% balance is required at the time of pick-up.** Glasses and contacts purchases are **NON-REFUNDABLE**, but we will make every effort to ensure your satisfaction.

For your convenience, we accept cash, checks, Visa, Mastercard, and Discover cards.

Authorization: *I hereby authorize the release of any medical information necessary to process my insurance and authorize payment directly to Chicagoland Eye Consultants, S.C. dba Advanced Vision Specialists. I understand that I am financially responsible for charges not covered by my insurance and any balance will be paid by me upon receipt of the bill.* ***There is a fee (currently $35.00) for any checks returned by the bank. A Service charge will be added for all accounts released for collection.***

_____ _____

(Signature of Patient or Responsible Party) **(Date)**

TURN OVER PLEASE

Signature on File

_____ PRINT Patient Name

_____/_____/_____/_____ Medicare Identification Number

1. MEDICARE

I request that payment of authorized Medicare benefits be made on my behalf to Chicagoland Eye Consultants, S.C. dba Advanced Vision Specialists. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated, my signature authorizes releasing the information to the insurer or agency shown.

Chicagoland Eye Consultants, S.C. dba Advanced Vision Specialists accepts the allowed charge determination of the Medicare carrier as the full charge and I am responsible only for the deductible, coinsurance, and non-covered services.

_____ Signature of Patient

_____ Date

2. Secondary Insurance or other Insurance if not covered by Medicare

I hereby authorize payment of my medical and surgical insurance benefits to Chicagoland Eye Consultants, S.C. dba Advanced Vision Specialists. I understand I am financially responsible for any charges whether or not paid by said insurance. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Chicagoland Eye Consultants, S.C. dba Advanced Vision Specialists. I authorize Chicagoland Eye Consultants, S.C. dba Advanced Vision Specialists to release any information required to process any and all claims for reimbursement on my behalf. A copy of this authorization may be used in place of the original.

_____ Signature of Patient

_____ Date

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With your consent, Chicagoland Eye Consultants,S.C. dba Advanced Vision Specialists may use and disclose protected health information about you to carry out treatment, payment and health care operations. Our *Notice of Privacy Practices* provides more detailed information about such uses and disclosures. You have a legal right to review our Notice of Privacy Practices prior to signing this consent, and we encourage you to read it in full.

As part of your healthcare, Chicagoland Eye Consultants, S.C. dba Advanced Vision Specialists originates and maintains health records describing your health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

The information we collect serves as a basis for planning your care and treatment; a means of communication among the many healthcare professionals who contribute to your care; a source of information for applying your diagnosis and surgical information for billing purposes; a means by which a third-party payer can verify that services billed were actually provided; and a tool for routine healthcare operations such as assessing quality care and reviewing the competence of your healthcare professionals.

With your consent, Chicagoland Eye Consultants, S.C. dba Advanced Vision Specialists may mail or call your home or office and leave a message in reference to information that assists us in carrying out treatment, payment and healthcare operations, such as appointment reminders, insurance and billing issues and any call pertaining to your clinical care.

By signing this form, you are consenting to our use and disclosure of your protected health information for the purposes of treatment, payment or healthcare operations. This consent may be revoked in writing, except to the extent that we may have already made disclosures in reliance upon your prior consent.

You may release information to: _____

Signed: _____ Date: _____

If you are not the patient, please specify your relationship _____

Patient File Copy

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DILATION CONSENT

Dear Patient:

We are pleased to inform you that our office can provide you with one of the most thorough eye exams available. In order for us to thoroughly view the retina (the tissue that lines the inside of the eye) and other internal structures, we may need to dilate your eyes.

Dilation consists of placing drops in your eyes which will enlarge your pupils (the black circle in the center of the colored part of your eye). Dilation usually occurs within 15 minutes, after the drops are instilled. Due to the widening of the pupil, **dilation will affect the comfort and ability of many patients when reading and may also cause light sensitivity**. **If possible, someone should accompany you to our office to drive you home, as dilation can impair your ability to drive**. If that is not possible, **you should use caution when driving or engaging in other hazardous activities, while your pupils are dilated**. Disposable sun shades will be given to you after dilation, to protect your eyes in bright illumination, if you have not brought your own sunglasses. If you did not receive sun shades before you leave, please ask our Reception Staff for a pair.

We wholeheartedly recommend dilation, especially if you or a family member has a history of diabetes, retinal disease, flashes or floaters, glaucoma, cataracts, macular degeneration, a moderate or high degree of nearsightedness, or if you have not had your eyes dilated within the past year or two. In some cases, dilation may be the only effective way of detecting diseases of the retina and other internal structures of the eye.

I have read and understand the importance of dilation and that it would be in my best interest for evaluating the health of my eyes, and **hereby give consent**.

Signed: ______________________________ **Date:** ____________________

** Signature valid for 12 months from this date*

Sincerely,

Jasmeet Dhaliwal, M.D.

**I understand the importance of dilation and that it would be in my best interest for evaluating the health of my eyes, however, at this time, I decline to be dilated.*

Signed: ______________________________ Date: ____________________

**Signature valid for 12 months from this date*