SUBURBAN
EYES
CLINIC

PATIENT REGISTRATION

(Please print and complete all entries on both sides)

Patient Information

Date: _____

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss

Name _____ Social Security No. _____
First M.I. Last

Address _____ Date of Birth _____

City _____ State _____ Zip _____ Sex ☐ Male ☐ Female

Home Phone _____ Driver's License No. _____

Cell Phone _____ Marital Status ☐ Single ☐ Married

Work Phone _____ ☐ Divorced ☐ Widowed

May we leave medical information with family members? ☐ Yes ☐ No

Or on your home answering machine? ☐ Yes ☐ No

Referring Doctor _____ Address _____

Referring Doctor's Phone _____ _____

Guarantor Information

(responsible for bill, if different from above)

Name _____

Home Address _____

City _____ State _____ Zip _____

D.O.B. _____ Soc. Sec. No. _____

Name of Employer _____

Employer's Address _____

City _____ State _____ Zip _____

Work Phone No. _____

Occupation _____

Driver's License No. _____

Guarantor's Spouse

Name _____

Soc. Sec. No. _____

Work Phone No. _____

Optometric Services (Refraction). If you would prefer the exam for new glasses be performed at our office, the fee is $35.00, due at the time of the visit.

Authorization to Pay Benefits to Physician

I hereby authorize my insurance company to forward payment directly to Suburban Eyes Clinic for surgical and/or medical benefits, if any, otherwise payable to me. I understand that I, as insured, remain responsible for prompt payment of all services regardless of insurance coverage.

Signed _____ Date _____

Emergency Contacts

Who to notify in case of emergency

Name _____ **Relationship** _____

Address _____ **Phone** _____

Medical History

Reason for Visit _____

Previous eye surgery or injury _____

Allergies _____

Please list all medications you are currently taking _____

_____

Authorization to Pay Benefits to Physician

I hereby authorize my insurance company to forward payment directly to Suburban Eyes Clinic for surgical and/or medical benefits, if any, otherwise payable to me. I understand that I, as insured, remain responsible for prompt payment of all services regardless of insurance coverage.

Signed _____ **Date** _____

Patient Financial Agreement

No Call/No-show Policy: If you are unable to keep a scheduled appointment, please notify our office 24 to 48 hours in advance **otherwise there will be a $40.00 no-show fee**. Any delay, of 15 min. or more may require the visit to be rescheduled at our discretion.

Medical Eye Care: Payments for all services rendered by this office are the responsibility of the patient. Regardless of the amount or type of insurance you or your employer has purchased, each patient assumes full responsibility for all fees incurred. You are responsible for all charges not paid by your insurance carrier What your insurance company deems medically necessary has no bearing on the quality of care we provide. Our services are aimed at providing you with the best care possible, regardless of insurance. **If you do not have insurance a full payment is due at time of service.**

Co-Pays: Due at the time of service.

Medicare: We participate in Medicare program. You are responsible for your co-insurance, any deductibles that have not yet been met, and services that are identified as patient responsibility on your Medicare Explanation of Benefits.

Managed Care/HMOs: Many patients are enrolled in Managed Care Products. In order for us to obtain referrals and/or pre-authorizations for procedures, it is important that we have your current insurance information. Depending on individual policies, your procedure may not be a covered benefit. **It is your responsibility to check for optimal coverage and policy limitations, and to obtain referrals as required by your insurance company.** Please contact your insurance company with questions regarding your coverage.

Refraction: As mandated by Federal law, the refraction (determination of eyeglass prescription) is a non-covered service. Each patient will be charged for the refraction at the time of service during your visit.

Methods of Payment: We take all major credit cards, debit cards, cash, and checks. Balances due, not withstanding insurance balances, that are not paid in full within 90 days may be turned over to an outside collection agency for final payment. We will bill insurance claims for you as a courtesy.

I have read and understand the office financial policies and agree to the conditions above and further agree that I, as the patient receiving services or the responsible party for the patient, am ultimately responsible for payment of any materials ordered and/or services rendered.

Print Name: _____

Date: _____

Signature: _____

Phillip C. Wu, M.D.
Suburban Eyes Clinic
500 Davis St, Suite 810
Evanston, IL 60201

HIPAA ACKNOWLEDGEMENT/CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Print Patient Name _____

Signature _____

Signature Date _____

Relationship to Patient (if patient unable to sign) _____