



David Badawi, M.D.
Brittany Osgood, M.D.
Kara Schultz, M.D.

REGISTRATION FORM

Today's Date:		PCP:	
PATIENT INFORMATION			
Patient's last name:	First:	Middle:	Ms./Mrs./Miss./Mr. Marital status: [Choose an item]
		SINGLE ☐ DIVORCED ☐ MARRIED ☐ WIDOWED ☐ SEPARATED ☐	
Street Address	City/State/Zip	Birth date:	Age: Sex: ☐ M ☐ F
Email:		Home phone no.:	Cell phone no.:
Occupation:		Employer:	Employer phone no.:
Other family members seen here: [Other patients]			
INSURANCE INFORMATION (Please give your insurance card to the receptionist.)			
Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:
Is this person a patient here?	☐ Yes ☐ No	Is this patient covered by insurance?	☐ Yes ☐ No
Occupation:	Employer:	Employer address:	Employer phone no.:
Please indicate primary insurance: [Choose an item] Other:			
Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.: Policy no.: Co-payment:
Patient's relationship to subscriber: [Choose an item] Other: [Relationship to subscriber]			
Name of secondary insurance (if applicable):	Subscriber's name:		Group no.: Policy no.:
Patient's relationship to subscriber: [Choose an item] Other: [Relationship to subscriber]			
IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.			
Patient/Guardian signature: _____		Date: _____	
Print Name: _____			



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Refraction

A refraction is a measurement that determines the best vision your eyes have, it is necessary if you would like to have a **new glasses prescription or contact lenses**, or if you have had a **change in your vision**. Determining your best vision is the only way to begin evaluating your eye health. We perform refraction using several precise and highly technical instruments as well as the expertise of our certified ophthalmic assistants and our physicians. If you are scheduled for a **"routine"** of **"full" eye exam, we will perform refraction**.

Most medical insurance plans, including Medicare, do NOT consider a refraction to be part of a comprehensive eye exam. Medicare will not pay for this service. Your secondary coverage will not cover if Medicare does not. However, Medicare allows us to charge and be paid for this service.

Our office fee for refraction is **\$50.00**. If refraction is a necessary part of your exam today, we will perform it and you will be asked to **pay the fee at check-out**. Should your insurance plan pay for the refraction, we will reimburse you accordingly.

Consider choosing an optical shop (eyeglass vendor) that has a reasonable exchange or return policy. We are not responsible for costs to change, replace, or exchange glasses.

Patient Name: _____ Date: _____

Signature of patient or Legal guardian.

Information Regarding Dilating Eye Drops

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye.

Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it's best if you make arrangements not to drive yourself.

Adverse reaction, such as acute angle closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

Patient Acknowledgment

- I understand the refraction policy.
- I hereby authorize Central Eye Care, LTD. staff to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

Patient Name: _____ Date: _____

Signature of patient or Legal guardian.

phone 847.978.4535	3030 Salt Creek Lane
fax: 847.960.5378	Suite 300
www.arlingtoneyes.com	Arlington Heights, Illinois 60005



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CONSENT TO OBTAIN PATIENT MEDICATION HISTORY

Patient medication history is a list of prescriptions that healthcare providers have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history.

The collected information is stored in the practice electronic medical record system and becomes part of your personal medical record. Medication history is very important in helping providers treat your symptoms and/or illness properly and avoid potentially dangerous drug interactions.

It is very important that you and your provider discuss all your medications in order to ensure that your recorded medication history is 100% accurate. Some pharmacies do not make prescription history information available, and your medication history might not include drugs purchased without using your health insurance.

Also, over-the-counter drugs, supplements, or herbal remedies that you take on your own may not be included.

I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

Pharmacy Name: _____

Pharmacy Location: _____

Primary Care Provider (PCP): _____

Referring Provider: _____

For 65 and older:

Have you ever received a pneumonia vaccination? Yes / No

Patient Name: _____

Date: _____

Signature of patient or Legal guardian.



FINANCIAL POLICY

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Thank you for choosing us as your health care provider. We are committed to building a successful physician-patient relationship with you and your family. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign the space provided. A copy will be provided to you upon request.

1. Insurance Claims. We participate in most insurance plans, including Medicare. If you are not insured by a plan, we do business with, payment in full is expected at each visit. If you are insured by the plan, we do business with but don't have an up-to-date insurance card, payment in full is required for each visit until we can verify your coverage. Knowing your insurance is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

**AS MEDICAL DOCTORS, WE DO NOT BILL ANY EXAMS AS ROUTINE EXAMS.
AND WE ONLY ACCEPT MEDICAL INSURANCE (NO VISION PLANS).**

2. Co-pays and deductibles. The patient is expected to present an insurance card at each visit. All co-payments and past due balances are due at time of check-in unless previous arrangements have been made with a billing coordinator. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your copayment at each visit. We accept cash, check or credit cards.

3. Non covered Services. Please be aware that some of your services may be considered "non-covered" (such as Refractions). For these non-covered services, we ask for full payment at the time of service. If your insurance carrier may provider coverage, you will be given a refund.

3. Referrals and Preauthorizations. Certain health insurances (HMO, POS, etc.) require that you obtain a referral or prior authorization from you Primary Care Provider (PCP) before visiting a specialist. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower or no payment from the insurance company, and the balance will be your responsibility. Alternative payment arrangements or rescheduling of your appointment may be necessary if not obtained.

4. Self-pay Accounts. Self-pay accounts are patients without insurance coverage, patients covered by insurance plans in which the office does not participate, or patients without an insurance card on file with us. Liability cases will also be considered self-pay accounts. We do not accept attorney letters or contingency payments. It is always the patient's responsibility to know if our office is participating with their plan. If there is a discrepancy with our information, the patient will be considered self-pay unless otherwise proven. Extended payment arrangements are available if needed. Please ask to speak with a billing coordinator to discuss a mutually agreeable payment plan. It is never our intention to cause hardship to our patients, only to provide them with the best care possible and the least amount of stress.

5. Workers' Compensation. Charges for services incurred as a result of a verified work-related injury will be treated as a worker's compensation and we will bill the carrier as a courtesy. You must provide the necessary information to bill the carrier. You are responsible for the completion of information with the employer and carrier.

6. Missed Appointments. Central Eye Care requires 24-hour notice of appointment cancellation. Appointments missed and are not previously canceled may be charged a fee of \$50.00.

Returned Checks. The charge for a returned check is \$25 payable by cash or money order. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash only basis following any returned check.

Medical Record Copies

Patients requesting copies of medical records will be charged:
\$15 – under 20 pages

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines.

Signature of patient or responsible party:

Patient Name: _____ Date: _____

Signature of patient or Legal guardian: _____

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CONSENT TO TREATMENT

I hereby give my permission for Central Eye Care (the Practice) to give me medical treatment.
I allow the Practice to file for insurance benefits to pay for the care I receive.

I understand that:

- the Practice will have to send my medical record information to my insurance company.
- I must pay my share of the costs.
- I must pay for the cost of these services if my insurance does not pay or I do not have insurance.

I understand:

- I have the right to refuse any procedure or treatment.
- I have the right to discuss all medical treatments with my provider.

Patient Name: _____ Date: _____

Signature of patient or Legal guardian.

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Central Eye Care (the Practice) to use and disclose my protected health information (PHI) to perform treatment, payment and health care operations (TPO).

With this consent, the Practice may call me, text me or email me to my home or other alternative location and leave a message by voice, email or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and anything pertaining to my clinical care, including laboratory test results.

With this consent, the Practice may mail to my home or other alternative location any items that assist the practice in performing TPO, such as appointment reminder cards, patient statements and anything pertaining to my clinical care as long as they are marked "Personal and Confidential."

By signing this form, I am consenting to allow the Practice to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the Practice has already made disclosures upon my prior consent. If I do not sign this consent, or later revoke it, the Practice may decline to provide treatment to me.

Patient Name: _____ Date: _____

Signature of patient or Legal guardian.



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HIPAA Privacy Rule of Patient Authorization Agreement
Authorization for the Disclosure of Protected Health Information for Treatment,
Payment, or Healthcare Operations (§164.508(a))

I understand that as part of my healthcare, this Practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment;
- a means of communication among the health professionals who may contribute to my health care;
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payer can verify that services billed were actually provided;
- a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I have been provided with a copy of the **Notice of Privacy Practices** that provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this Practice's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

Privacy Rule of Patient Consent Agreement
Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or
Healthcare Operations (§164.506(a))

I understand that:

- I have the right to review this Practice's Notice of Information practices prior to signing this consent;
- that this Practice reserves the right to change the notice and practices and that prior to implementation will mail a copy of any notice to the address I've provided, if requested;
- I have the right to object to the use of my health information for directory purposes;
- I have the right to request restrictions as to how my Protected Health Information may be used or disclosed to carry out treatment, payment, or healthcare operations, and that this Practice is not required by law to agree to the restrictions requested;
- I may revoke this consent in writing at any time, except to the extent that this Practice has already taken action in reliance thereon.

Patient Name: _____

Date: _____

Signature of patient or Legal guardian.