The Vision Institute of Illinois

Comprehensive Ophthalmology

Name_____

Birthdate____/_____/_____

LIST OF CURRENT MEDICATIONS

NAME	DOSE
1)	
2)	
3)	
4)	
5)	
6)	
7)	
8)	
9)	
10)	

LIST ALLERGIES TO MEDICATIONS ☐ No known drug allergies

NAME	REACTION
1)	
2)	
3)	
4)	

PREVIOUS INJURIES	APPROXIMATE DATE
1)	
2)	
3)	
4)	

PREVIOUS SURGERY	YEAR	HOSPITAL
1)		
2)		
3)		
4)		

DO *YOU* HAVE ANY OF THE FOLLOWING MEDICAL PROBLEMS?

☐ Arthritis	☐ High Blood Pressure	☐ High Cholesterol	☐ Kidney Disease	☐ Thyroid disease
☐ Blindness	☐ Glaucoma	☐ Diabetes	☐ Cancer	☐ Heart Disease
☐ Asthma	☐ Seizures	☐ Hearing Loss	☐ Bronchitis	☐ Colitis
☐ Stroke	☐ Tuberculosis	☐ Other _____		

Do you Smoke? ☐ No ☐ ½ Pack Daily ☐ 1 Pack Daily ☐ More ☐ Former, Quit date_____

How much alcohol do you drink? ☐ None ☐ Rarely ☐ Socially ☐ Daily

Elgin: 1750 N Randall Rd., Ste 200, Elgin, IL, 60123
Barrington 602 Fox Glen Ct., Barrington, IL 60123

Ph: 847-277-0555
Fax: 847-277-0444
www.visioninstituteil.com

The Vision Institute of Illinois
Comprehensive Ophthalmology

Name_____

Birthdate_____/_____/_____

Are you currently, or have you had, problems with:

Constitutional	*Circle One*	
Weight gain	Yes	No
Weight loss	Yes	No
Night sweats	Yes	No
Insomnia	Yes	No

Eyes		
Tearing/burning/itching	Yes	No
Crossed eye/lazy eye	Yes	No
Glaucoma	Yes	No
Cataract	Yes	No
Injuries	Yes	No
Macular Degeneration	Yes	No

Allergic/Immunologic		
Sneezing	*Yes*	*No*
Itchy eyes/nose	*Yes*	*No*
Itchy throat	*Yes*	*No*
Skin rash	*Yes*	*No*
HIV	*Yes*	*No*

Ear, Nose, Throat and Mouth		
Hearing loss	Yes	No
Noise/ringing in ears	Yes	No
Nasal congestion	Yes	No
Nasal drainage	Yes	No
Sore throat	Yes	No
Trouble swallowing	Yes	No
Hoarseness	Yes	No

Endocrine		
Diabetes	Yes	No
Thyroid disease	Yes	No

Respiratory		
Asthma	Yes	No
Coughing up blood	Yes	No
TB	Yes	No
Pneumonia	Yes	No
Trouble breathing at night	Yes	No
Snoring	Yes	No

Cardiovascular		
Chest pain or angina	Yes	No
Heart trouble	Yes	No
Rheumatic fever	Yes	No
Heart murmur	Yes	No
High blood pressure	Yes	No

Gastrointestinal		
Indigestion or heartburn	Yes	No
Ulcer	Yes	No
Hepatitis	Yes	No
Jaundice	Yes	No
Blood in stool	Yes	No
Black, tarry stools	Yes	No

Hematologic		
Bleeding disorder	Yes	No
Easy bleeding	Yes	No

Genitourinary		
Bladder trouble	Yes	No
Prostate disease	Yes	No
Kidney disease	Yes	No

Musculoskeletal		
Arthritis	Yes	No

Neurological		
Numbness	Yes	No
Weakness	Yes	No
Stroke	Yes	No
Headache	Yes	No

Psychiatric		
Depression	Yes	No

IS THERE A FAMILY HISTORY OF THE FOLLOWING MEDICAL PROBLEMS? (Please specify family member)

☐ Arthritis_____	☐ Tuberculosis_____
☐ Cancer_____	☐ High Blood Pressure_____
☐ Asthma_____	☐ Seizures_____
☐ Hearing Loss_____	☐ Thyroid Disease_____
☐ Diabetes_____	☐ Macular Degeneration_____
☐ Blindness_____	☐ Colitis_____
☐ Heart Disease_____	☐ Bronchitis_____
☐ Stroke_____	☐ Kidney Disease_____
☐ Glaucoma_____	☐ High Cholesterol_____

The above information is accurate to the best of my knowledge.
Patient Signature _____
Date_____

Elgin: 1750 N Randall Rd., Ste 200, Elgin, IL, 60123
Barrington 602 Fox Glen Ct., Barrington, IL 60123

Ph: 847-277-0555
Fax: 847-277-0444
www.visioninstituteil.com

The Vision Institute of Illinois

Comprehensive Ophthalmology

Patient Registration Form

Last Name: _____ First Name: _____ Middle Initial: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

SSN: _____-____-_____Birth Date: _____ Gender: Male/ Female Age: _____ Marital Status: S M W D

Please circle one: (We are required by law to ask for the information below.)

Race: American Indian, Asian, Native Hawaiian, African American, White, Hispanic, Other, Refuse to Report

Ethnicity: Hispanic or Latin, Not Hispanic, Refuse to Report Language: English, Spanish, Other_____

Email address: _____ **(Allows Consent for e-mail from our office)**

Home Phone: _____ Work Phone: _____Cell Phone: _____

Employer: _____ Occupation _____

Pharmacy Name_____ City _____ State_____

Intersection_____ Phone: _____ Mail order Pharmacy:_____

Emergency Contact Name: _____ Relation:_____ Phone:_____

Primary Care Physician: _____ Phone: _____

Primary Insurance: _____ ID #:_____

Group Number: _____ Name of Insured: _____

SSN of Insured: _____ Birth Date of Insured: _____ Relationship to Insured: _____

Secondary Insurance: _____ ID#:_____

Group Number: _____ Name of Insured: _____

SSN of Insured: _____ Birth Date of Insured: _____ Relationship to Insured: _____

How did you hear about us? Doctor Referral _____ Dr's Phone #_____
Patient Referral _____ Other _____

When canceling or rescheduling an appointment, 24 hour notice must be given or a $35 NO SHOW/CANCELLATION fee will be applied to my account. Patient Initials _____

I, the undersigned, grant permission to *Vision Institute of Illinois* to disclose medical information to other treating physicians regarding my care. I authorize the release to the Health Care Financing Administration or said insurance company and its agents any medical information about me to determine benefits payable for related services. I understand that, I the undersigned am legally responsible for all fees related to medical services rendered, including copayments, coinsurance and deductibles.

_____ _____
Patient's Signature Date

Elgin: 1750 N Randall Rd., Ste 200, Elgin, IL, 60123
Barrington 602 Fox Glen Ct., Barrington, IL 60123

Ph: 847-277-0555
Fax: 847-277-0444
www.visioninstituteil.com

The Vision Institute of Illinois

Comprehensive Ophthalmology

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I, _____, HAVE BEEN GIVEN THE OPPORTUNITY TO READ A COPY OF VISION INSTITUTE OF ILLINOIS' NOTICE OF PRIVACY PRACTICES.

X _____ X _____

DATE SIGNATURE OF PATIENT

If you are not the patient, Please specify your relationship to the patient:

PATIENT COMMUNICATION AUTHORIZATION

Person(s) Authorized to received information about my healthcare

Name:_____Relationship:_____Date of Birth:_____/_____/_____

Name:_____Relationship:_____Date of Birth:_____/_____/____

Name:_____Relationship:_____Date of Birth:_____/_____/____

Name:_____Relationship:_____Date of Birth:_____/_____/____

I authorize physicians and staff to communicate and/or leave messages for me at:

Home: Yes_____ No_____ Number_____

Work: Yes_____ No_____ Number_____

Cell: Yes_____ No_____ Number_____

Text Message: Yes_____ No_____

Mail: Contact me at this address: _____

I authorize Vision Institute of Illinois to send marketing materials to:

My Home Address: Yes_____ No_____ **Email:** Yes_____ No_____

Other requests for Confidential Communications:

_____

_____

Elgin: 1750 N Randall Rd., Ste 200, Elgin, IL, 60123
Barrington 602 Fox Glen Ct., Barrington, IL 60123
Ph: 847-277-0555
Fax: 847-277-0444
www.visioninstituteil.com

The Vision Institute of Illinois

Comprehensive Ophthalmology

PATIENT FINANCIAL POLICY

Patient Name: _____ **Birthdate:** _____/_____/_____

Thank you for choosing Vision Institute of Illinois for your medical care. We are committed to the success of your medical treatment and care. Please understand that a mutual financial understanding is part of our relationship.

We sincerely hope that by sharing our financial expectations we will strengthen the practice-patient relationship and keep the lines of communication open. This financial policy helps the practice provide quality care to our valued patients. If you have any questions or need clarification of any of the above policies, please feel free to contact our office manager at 847-277-0555.

Payment is Due At the Time of Service

- We accept cash, checks, debit, and credit cards.
- All co-payments, deductibles and non-covered services are due at the time of service unless you have made payment arrangements in advance of your appointment.
- Insurance required co-payments are due when you check in for your appointment. If you arrive without your co-payment, we may ask you to reschedule. We charge an administration fee of $25.00 for co-payments not paid at the time of check in.
- If your co-payment is based on a percentage (example: 20% of the allowed payment) and you do not have a secondary policy, please be prepared to pay a minimum of $40.00 on the date of service.
- Patient-responsible balances are due when you check in for your appointment.
- In the event you need surgery and you do not have health insurance coverage, we must receive down payment of no less than 50% of the estimated doctor's fees before we will schedule the surgery. The
- We request that at least **24 hour** advance notice be given to the office if you will be unable to keep your scheduled appointment. All cancellations with less than 24 hours notice and no-shows will be billed $35.00 per occurrence. Patients will be expected to pay the $35.00 fee prior to, or at the time of their next appointment. If we need to bill you, the $25.00 administrative fee will be applied in addition to the cancellation/no-show fee. Patients who repeatedly "no show" for appointments may be discharged from the practice.
- There is a $25.00 fee for checks returned non-sufficient funds

Patient Initials_____

Proof of Insurance

- Please bring your insurance card(s) and a valid photo ID with you to each appointment.
- It is your responsibility to notify the practice of changes in your health insurance.

Patient Initials_____

Self Pay

- We designate accounts, **Self-Pay**, under the following circumstances: (1) patient is covered by an insurance plan that our physicians do not participate in, (2) patient does not have a current, valid insurance card on file, (3) patient does not have a valid insurance referral on file, or (4) patient does not have health insurance coverage.

Patient Initials_____

Referrals

- If you have an HMO plan we are contracted with, you need a referral authorization from your primary care physician. It is your responsibility to call our office 24-48 hours prior to your appointment to see if we have received your referral. If we have not received an authorization prior to your arrival at the office, call your primary care physician to obtain it. If you are unable to obtain the referral at that time, you will be rescheduled or asked to pay for the visit in advance.

The Vision Institute of Illinois
Comprehensive Ophthalmology

Patient Initials_____

Our Responsibility to Report Non-Compliance

- It is our obligation under many of the insurance contracts to report patients who: repeatedly refuse to pay co-payments/deductibles at time of service, or who repeatedly "no show" for appointments.

Patient Initials _____

Divorce and Child Custody Cases

- In cases of divorce, the individual who receives care is responsible for payment of co-payments, coinsurance, deductibles, and nonparticipating insurance balances at the time of service. We will not bill a divorced spouse for the patient's services.
- The parent who brings the child to the office for care is responsible for payment at the time of service no matter if the account is self-pay, participating insurance, or nonparticipating insurance. The practice does not honor divorce specifics (*e.g., percentage of financial responsibility).*
- If the child has coverage with a participating insurance plan and the proper insurance identification is present at the time of service, the practice will bill that insurance company. Applicable co-payments, coinsurance and/or deductibles are due at the time of service, unless arrangements have been made with the office prior to arrival.

Patient Initials_____

Billing, Payments and Refunds

- All balances are due in full within 14 days of the statement date.
- If you cannot pay the balance in full with 14 days, please contact our billing department to see if you qualify for special payment options.
- It is your responsibility to notify the office of any change in address, phone, employment, or insurance coverage.
- If you make an overpayment on your account, we will issue a refund only if there are no other outstanding debts on other accounts with the same guarantor or financial responsible party.
- We reserve the right to report delinquent accounts to credit bureaus, assess a collection fee, take other collection action, or terminate you as a patient of this practice.

Patient Initials_____

PLEASE INITIAL BELOW

_____**I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable copayments and deductibles, are my responsibility.**

_____I authorize my insurance benefits be paid directly to Vision Institute of Illinois.

_____I authorize Vision Institute of Illinois, through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures.

_____I authorize Vision Institute of Illinois to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment.

X Patient/Guarantor Signature_____Date_____

Elgin: 1750 N Randall Rd., Ste 200, Elgin, IL, 60123
Barrington 602 Fox Glen Ct., Barrington, IL 60123
Ph: 847-277-0555
Fax: 847-277-0444
www.visioninstituteil.com

The Vision Institute of Illinois

Comprehensive Ophthalmology

Name Last	First	Middle	Maiden/Other	Date of Birth

Address	City	State	Zip Code	Telephone Number

I Authorize and Request:

Name and Address

_____

_____

_____

_____

To release to:

☐ Dr. Nishat Alvi

☐ Dr. Saba Quraishi

Appointment Date: _____

The Following information:

☐ **All Ophthalmology Records on paper or EMR,**

Including but not limited to:

Ophthalmology Progress Notes plus Snapshot

OCT (Optical Coherence Tomography) in Color

Ophthalmology Diagnostic Tests **Fundus Photos in Color**

Contact Lens Records **Visual Fields**

Ophthalmology Operative Notes **Corneal Topography**

The Following Information:

☐ **All Otolaryngology Records on paper or EMR,**

Including but not limited to:

ENT Progress Notes plus Snapshot

Radiology Reports **Laboratory Reports**

Pathology Reports **ENT Procedures**

ENT Operative Notes

I understand that this information disclosed could contain mental health, developmental disabilities, alcohol and drug abuse, and/or Acquired Immune Deficiency Syndrome (AIDS) / HIV information. I understand that I have the right to inspect and/or obtain a copy, (for the appropriate fee) of the information prior to disclosure. I understand that if I do NOT disclose needed information it could affect my insurance companies' ability to pay for a claim associated with this visit and I may be responsible for any charges. I may revoke this authorization at any time (except to the extent that action has already been taken) by submitting a written revocation to the facility. This authorization will be considered valid for a 90 day period following the date of signature, unless otherwise specified here: _____ _____. I absolve the individual or agency identified above together with its officers and employees from any legal liability which may arise from the disclosure of this information.

Patient Signature _____ **Date Signed**_____

Witness Signature _____ **Date Signed** _____

Elgin: 1750 N Randall Rd., Ste 200, Elgin, IL, 60123
Barrington 602 Fox Glen Ct., Barrington, IL 60123

Ph: 847-277-0555
Fax: 847-277-0444
www.visioninstituteil.com