EYE CLINICS OF ILLINOIS

409 W Ogden Ave
Westmont IL 60559
630-964-9800

7001 W Archer Ave
Chicago IL 60638
773-229-8818

12150 S Harlem Ave
Palos Heights IL 60463
708-274-8700

PATIENT INFORMATION

PLEASE CIRCLE: DR. MR. MRS. MISS. MS.

PATIENT NAME: _____ BIRTHDATE: ____/____/____

ADDRESS: _____ SOCIAL SECURITY #:_____

CITY/STATE/ZIP: _____ MALE _____ FEMALE _____

HOME PHONE NUMBER: _____

CELL PHONE NUMBER: _____

MARITAL STATUS: S____ M____ W____ D____

EMAIL ADDRESS: _____ *(PLEASE PRINT)*

EMERGENCY CONTACT: _____PHONE #: _____

WHO REFERRED YOU TO OUR OFFICE? _____

(X)

_____

(SIGNATURE)

I REQUEST THAT PAYMENT OF MEDICARE AND/OR INSURANCE BENEFITS BE MADE PAYABLE DIRECTLY TO B. Narayan Ponakala, M.D FOR ANY SERVICES FURNISHED TO ME BY THE PROVIDER. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE INSURANCE CARRIER ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES. **I UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE FOR PAYMENT OF SERVICES.**

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NOTICE OF PRIVACY PRACTICES RECEIPT

I acknowledge that I was provided with the Notice of Privacy Practices of the Medical Practice named at the top of this page.

Print Name of Patient: X_____

Signature of Patient: X_____

Date: X_____

Patient's Date of Birth X_____

For Personal Representative of the Patient (if applicable)

Print Name of Personal Representative: _____

Describe Personal Representative Relationship: _____

(parent, guardian, etc.)

Signature of Personal Representative: _____

Date: _____

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FINANCIAL POLICY

January 1, 2025

1. **PAYMENT** is expected at the time of your visit. We will accept cash, credit card or check. Payment will include any unmet deductible, co-insurance, co-payment or any non-covered charges from your insurance company. If you do not carry insurance payment in full is expected at the time of your visit.

2. **INSURANCE –** We are participating providers with several insurance plans. We will file all of these insurance claims. A list of these insurance plans in available upon request. Please remember that insurance is a contract between the patients and the insurance company and ultimately the patient is responsible for payment in full. I your insurance company does not pay the practice within a reasonable period of time, you will be billed. If we later received payment from your insurer, we will refund any over payment back to you.

   If our doctor's are not listed in your plan's network, you may be responsible for partial or full payment. If you are insured by a plan with which we have no prior arrangement, we will prepare and send the claim in for you on an unassigned basis. This means the insurer may send the payment directly to you and therefore, our charges for you are due at the time of the service. Due to many different insurance products out there, our staff cannot guarantee your eligibility and coverage. Be sure to check with your insurer's member benefits department about services and physicians before your appointment. Many websites have erroneous information and are not guarantee of coverage. You're responsible for obtaining a properly dated **referral** if required by your insurer and you're responsible for payment if your claim rejects for the lack of one.

   Not all insurance plans cover all services. In the event your insurance plan determines a service to be 'not covered,' you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. All procedures billed in this office are considered covered unless limited by our specific insurance policy.

3. **RETURNED CHECKS** will incur a $30.00 service charge. You will be asked to bring cash or money order to cover the amount of the check plus the $30.00 service charge to pay the balance prior to receiving services from our staff or physician. Stop payments constitute a breach of payment and re subject to the $30.00 service.

4. **ACCOUNTING PRINCIPALS –** Payments and credits are applied to the oldest charges first, except for insurance payments which are applied to the corresponding dates of service.

5. **FORMS FEES –** Copying medical records requires office staff time and away from patients care for our doctors. We require a payment of $25 per chart for copying medical records.

6. **BILLING OFFICE –** If you have any questions with respect to any of the billing statements, please call our offices and they will assist you.

7. **RESPONSIBILITY OF PAYMENT -** I understand that I personally am financially responsible to EYE CLINICS of ILLINOIS for charges not covered by the assignment of insurance benefits.

   → Initial _____

8. **ASSIGNMENT OF INSURANCE BENEFITS** – I hereby assign, transfer and set over directly to EYE CLINIS of ILLINOIS.

   → Initial _____

I HAVE READ AND UNDERSTOOD THE PRACTICES FINANCIAL POLICY AND I AGREE TO BE BOUND BY ITS TERMS. I ALSO UNDERSTAND AND AGREE THAT SUCH TERMS MAY BE AMENDED BY THE PRACTICE FORM TIME TO TIME.

_____ _____

Signature of Patient **Date**

Confidential Medical Questionnaire

Name: _____ Date:_____

Do you <u>currently</u> have any problems in the following areas? Please mark YES or NO

EYES:

Decreased vision at distance	YES	NO
Decreased vision at near	YES	NO
Distorted vision (halos)	YES	NO
Fluctuating vision	YES	NO
Tired eyes	YES	NO
Flashing lights	YES	NO
Glare/light sensitivity	YES	NO
Night blindness	YES	NO
Floaters	YES	NO
Dryness, mucus discharge	YES	NO
Redness	YES	NO
Sandy or gritty feeling	YES	NO
Burning	YES	NO
Foreign body sensation	YES	NO
Pain or soreness	YES	NO
Chronic infection of eye or lid	YES	NO
Sties or chalazion	YES	NO
Blindness	YES	NO

Respiratory:

Asthma	YES	NO
Emphysema	YES	NO
Chronic cough	YES	NO

Cardiovascular:

Heart attack	YES	NO
High Blood Pressure	YES	NO
Pacemaker	YES	NO
Bypass	YES	NO
Chest pains	YES	NO
High cholesterol	YES	NO

Cancer: _____

OTHER _____

ARE YOU PREGNANT? _____

Hematological/Lymphatic:

Blood disorders	YES	NO
Anemia	YES	NO
Slow clotting time	YES	NO

Gastrointestinal:

Stomach/Intestines	YES	NO

Skin:

Eczema, psoriasis	YES	NO
Herpes	YES	NO

Genitourinary:

Bladder	YES	NO
Kidneys	YES	NO
Prostate	YES	NO

Endocrine:

Diabetes	YES	NO
Insulin	YES	NO
Pills	YES	NO
Thyroid	YES	NO

Musculoskeletal:

Bones/Joints/Muscles	YES	NO

Neurological:

Headache/Migraine	YES	NO
Stroke	YES	NO
Palsy	YES	NO

Psychological:

Depression	YES	NO
Anxiety	YES	NO

Name: _____ Date: _____

FAMILY HISTORY: (not yourself)			**PATIENT HISTORY: (YOU)**		
Glaucoma	YES	NO	Glaucoma	YES	NO
Blindness	YES	NO	Cataracts	YES	NO
Cancer	YES	NO	Macular Degeneration	YES	NO
Hypertension	YES	NO	Diabetic Retinopathy	YES	NO
Thyroid	YES	NO	Retinal Detachment	YES	NO
Cataract	YES	NO	Crossed Eyes	YES	NO
Crossed Eye	YES	NO			
Diabetes	YES	NO			
Kidney	YES	NO			
Stroke	YES	NO			

SOCIAL HISTORY:

DO YOU SMOKE? _____ YES _____NO HOW MUCH? _____

DO YOU DRINK ALCOHOL? _____ YES _____ NO HOW MUCH? _____

DO YOU USE DRUGS OR MEDICATIONS **NOT** PRESCRIBED BY YOUR DOCTOR?
_____ YES _____ NO IF SO, WHAT? _____

PAST HISTORY:

PLEASE LIST ANY **MEDICATIONS** THAT YOU ARE TAKING?

_____

PLEASE LIST ANY **SURGERIES** YOU HAVE HAD AND WHEN THEY WERE PERFORMED?

_____

PLEASE LIST ANY **ALLERGIES** THAT YOU HAVE?

_____

WHAT IS THE NAME OF YOUR FAMILY DOCTOR?

_____

TODAY'S DATE: _____

REVIEWED BY: _____

B. Narayan Ponakala, M.D

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OFFICE REFRACTION POLICY

A "refraction" is the process of determining the optimal eyeglass prescription for your eyes. This is not only to allow us to prescribe eyeglasses, but more importantly to determine your best corrected vision. The refraction helps us to distinguish whether vision problems are caused by glasses or from eye disease.

A refraction may or may not be performed at the time of your visit, depending upon doctor's judgment of its necessity. This service is not covered by Medicare and by most private insurances. If a refraction is performed, there will be a fee of $45.00.

It is our policy to collect the refraction fee at the time of service.

_____

Signature of Patient