Northwest Eye Clinic, Ltd.
1400 Golf Road, Suite 212
Des Plaines, IL. 60016-1252
FAX (847) 296-5926

Patient Registration

Patient Information

Patient Name (First, Middle, Last)	Suffix (Jr.,Sr.)	Salutation (Mr.,Ms.)	Nickname	Date of Birth	Today's Date	Social Security #	Birth State	Sex	Age
		.							

	Address Type (Home, Billing Address, Office/Business)	Country

Home Phone	Cell Phone	Work Phone / Ext	Email Address	Preferred Communication (Cell, Email)

Preferred Local Pharmacy	Preferred Mail Order Pharmacy

Primary Language	Special Needs	Marital Status	Maiden Name	Mother's Maiden Name	Plan Type

Gender Identity (Male, Female, Male-to-female transsexual, Female-to-male transsexual)	Sexual Orientation (Straight, Bisexual, Homosexual, Other, Don't Know)

Race	Race 2	Ethnicity	Ethnicity 2

Employer	Occupation

Responsible Party Information

Responsible Party's Name (Salutation, First, Middle, Last)	Date of Birth	Patient's Relationship to the Responsible Party (Self, Spouse, Child)	Home Phone	Cell Phone	Work Phone / Ext
		Self			

Address (Street, City, State, ZIP)	Email Address	Social Security #	Gender

			Total Balance

Primary Insurance

Insured's Name	Date of Birth	ID Number

Insurance Company Name	Insurance Co. Phone

Insurance Company Address	PAY %

Group Name	Group Number	Copay

Secondary Insurance

Insured's Name	Date of Birth	ID Number

Insurance Company Name	Insurance Co. Phone

Insurance Company Address	PAY %

Group Name	Group Number

Authorized Contacts (billing & medical record release)

Name/ Relationship/ Address	Title/ Specialty	Emergency Contact	Release Medical Info	Phone Numbers/ Fax

Legal, Work or Auto Injury Contacts

Name/ Numbers/ Fax	Role/ Title	Address	Release Medical Info	Claim Number/ Pertinent Info

Referring Physicians for coordination of care

Firm/Organization/Name	Phone and Fax	Address	Reason	Authorization Number

May we leave test results, medical information or medication information on your personal voice mail or answering machine? **Y/ N**

Do you currently reside in a skilled nursing facility **Y / N**

Is this visit due to an auto / work injury? **Y / N** Explain how your injury occurred:

_____

Assignment of benefits notification

I hereby instruct and direct Insurance Company(s) NWE has on my file to pay by check or direct deposit directly to Northwest Eye Clinic, Ltd., 1400 E. Golf Road, Suite 212, Des Plaines, IL 60016 for the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENIFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. A photocopy of this Assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case, to determine these benefits or the benefits payable for related services. I authorize my doctor to initiate a complaint to the Insurance Commissioner on my behalf. If you are an **HMO** patient, you must provide us with a referral or authorization number for every visit. By signing below, I understand that my medical claims may not be covered in full by my insurance company and I will be responsible for any balance. Routine eye care, eyeglasses, contact lenses, refraction's, and routine examinations are not covered by medical insurance. If I am an HMO patient and do not bring a referral for services provided by Northwest Eye Clinic, Ltd., I understand that I am responsible for any charges incurred. We do not accept any Medicaid plans. Medicaid portions will not be written off and will be patient responsibility. In the event my account balance becomes past due I understand there may be a late charge of 10% per billing cycle. Northwest Eye Clinic, Ltd. has financing and payment options at 0% financing available in the event payment cannot be promptly made, in the event financing or a payment agreement is made with Northwest Eye Clinic, Ltd. no late charges will apply. In the event my account is placed into collection Northwest Eye Clinic, Ltd. shall be entitled to recover all reasonable collection fees. Any request for medical records must be in writing, three to five days prior to receiving the records, charges for records may vary.

Notice of Privacy Practice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. Our commitment here at Northwest Eye Clinic, Ltd. is to serve or customers with professionalism and care, will be sure at all times to protect the privacy and security of all Protected Health Information. During the course of serving your interests it may be necessary to share information with other health care providers or business associates The following are examples of instances where this information can and will be shared:

- To conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- During treatment, we may find it necessary to acquire a laboratory analysis.
- Obtain payment from third-party payers, Insurance Companies, and billing services.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

We at Northwest Eye Clinic, Ltd. are committed to obeying all Federal, State and Local laws and regulations regarding Privacy Practices. If any other uses or disclosures than the ones listed above are needed, information will only be released with the written authorization of the individual in question. This written authorization may be revoked at any time by the individual, as provided by law. If you have any questions or comments regarding your Protected Health Information, feel free to contact out office at (847) 296-4020. I understand that, under the Health Insurance Portability & Accountability Act ("HIPPA"), I have certain rights to privacy regarding my Protected Health Information. I have received, read and understood your Notice of Privacy Practices. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that you may restrict how my private information is used or disclosed to carry out treatment, payment or health operations. I also understand you are not required to agree to my requested restrictions but if you do agree then you are bound to abide by such restrictions.

Signature _____ Date _____