Des Plaines Eye Care Center
782 W. Oakton Ave. #A, Des Plaines IL 60018
Tel: 224-236-2020

FINANCIAL & INSURANCE POLICY

1. Payment for services (including co-payment / co insurance / deductible) is DUE AT TIME OF SERVICE.
2. Verification of benefits by your insurance company and / or our office is not absolute guarantee of payment. If your insurance denies payment for any service, we promise to notify you in a timely manner. However, full payment is due within 30 days of notification.
3. Not all services and products are necessarily covered by insurance. Furthermore, those that are covered may be independent on your type of insurance, level of coverage, and previously exhausted benefits.
4. The parent who schedules / accompanies a minor to our office for an exam is responsible for payment. Our office cannot be involved in divorce settlements and/ or custody disputes.
5. DES PLAINES EYE CARE CENTER LLC retains the right to pursue a Collection Agency's help pursuing payments for outstanding accounts. In this event, the responsible party is liable for the unpaid accounts as well as collection fees of twenty percent of the uncollected balance.

I hereby acknowledge that I have thoroughly read, understand, and agree to the terms of this policy regarding insurance coverage and fee payment.

Patient's Signature: ______________________________ Date: ____________________
(or) Signature of Patient's Representative: ________________ Date: ____________________
Description of Patient's Representative: ______________________________ ____________________

HIPAA PRIVACY PRACTICES CONSENT

As a condition of providing treatment to you, our office must obtain your consent to use and disclose protected health information about you to carry out treatment, payment, and the health care operations of our office. You may revoke this consent at any time by notifying our office in writing, extent that our office in writing, except to the extent that our office has already taken action. You have the right to request our office to restrict the manner in which your protected health information is used or disclosed. Our office is not required to agree to such requested restrictions; however, we will do our best to comply with any such request.

I hereby consent to the use and disclosure of my protected health information by DES PLAINES EYE CARE CENTER LLC its work force, and its business associates for purposes of treatment, payment, and health care operations. I am aware I can request a copy of DES PLAINES EYE CARE CENTER LLC.
A Compliant "Notice of Privacy Practices" and it will be provided.
Patient's Signature: ______________________________ Date: ______________
(or) Signature of Patient's Representative: ______________ ______________Date: ______________
Description of Patient's Representative: ______________________________________

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Name: ___________________________________ ___________ **Sex:** __________
Birth Date: ___________________ **Today's Date:** ______________________
Street Address: ____
City: _________________________ **State:** _______ **Zip Code:** ____________
Preferred Phone: ____________ _______**Email:** _______________________

Emergency Contact Name: ____
Emergency Contact DOB: ____
Emergency Contact Phone Number: _________________________________
Emergency Contact Relation to Patient: _____________________________
Are other family members patients in our office? ____________________
How were you referred to our office? Family Friend Internet Groupon
If family or friend, please provide name: _________________________

Primary Care Provider Information
Name of Medical Doctor: _______________________________ **Last Medical Exam:** __________
Address: ____ **Phone Number:** ___________

The following questions help doctors and staff to provide you with the best possible vision care:
Occupation: ___________________________ Full Time: _____ Part Time: ________
Employer: _____________________ Work Phone:_____________
Student: Y: ____ N: _____ Does your position require extended computer work? Y: ___ N: ____
Hobbies/ Sports: ____

FINANCIAL/ INSURANCE INFORMATION
Person Responsible for this Account: _______________________________________
Medical Insurance Company :___________________________(Please present Insurance Card).
Vision Insurance Company: ____________________________ _(Please present Insurance Card).
If Vision and /or Medical Insurance is under the name of another person, please provide the following information so or office can file your claim in a timely manner.
Name of Insured: ____________________________Relationship to Patient: _______________
Insured's Place of Employment: ____
Social Security # of Insured: ___ -___ -___ Birth Date of Insured: ________________________
Address of Insured, if different than above: ____

***Vision plans cannot be billed for any patient being seen with a medical eye condition. These plans are strictly for well eye exams and do not apply if you have been diagnosed with a medical eye condition or complaints that might lead to a medical diagnosis. Most medical insurance policies do have some coverage for medical eye diagnoses.