NORTHERN ILLINOIS retina

1235 N. Mulford Suite 100 Rockford, IL 61107
815-226-4990

Dear Patient:

Your doctor has referred you to Northern Illinois Retina, and we look forward to meeting you. We are board-certified ophthalmologists who specialize in diagnosing and treating problems of the retina, vitreous and macula. We look forward to providing your retinal specialty care. If you are unable to keep your appointment please call us, and we will arrange another date or time. Failure to give an advanced notice of a cancellation may result in a "no-show" charge.

Because of the comprehensive nature of your visit, please have someone accompany you to your appointment. In addition to being a valued participant in our discussion of your eye problem, it is advised that you have a companion drive you home, as your eyes will be dilated.

Please be prepared to spend at least two hours with us. In that time, we will gather a full medical history and perform an eye examination-including dilation of the pupils and possibly special diagnostic testing such as retinal photography, fluorescein angiography, optical coherence tomography, or ultrasonography. After your examination, we will thoroughly explain our findings, discuss your condition with you, and make treatment recommendations.

In order to better familiarize us with your general and ocular health, as we expedite your visit, please fill out the patient history forms. All new patient forms may be downloaded from our website at www.niretina.com. Also, please bring any prescription glasses you may wear or a copy of your eyeglass prescription, any medication and eye drops you are currently using, and a list of names and addresses of the physicians that you currently see so that we can keep your doctors informed of your evaluation.

Be sure to bring all of your insurance cards and your photo ID with you when you come for this appointment. We participate with many insurance plans as well as Medicare. Payment for any co-payment and/or deductible is required at the time of your visit and may be made by cash, check or credit card. Payment for any estimated co-insurance amount will be requested at the time of service as well. Please understand that your failure to maintain a current account with us may result in the suspension of your treatment and/or your dismissal from the practice.

If you have any questions, please call us. Our office hours are 8:00am to 4:30pm Monday-Friday. Retinal specialist coverage is available 24 hours a day, seven days a week.

Sincerely,

The Staff and Doctors at Northern Illinois Retina

I understand that I will need to allow at least two hours minimum for this visit to allow for full medical history, vision and diagnostic testing, waiting for eyes to dilate, allowing physician time to review testing, and exam.

_____ _____

Signature Date

NEW PATIENT INFORMATION

Northern Illinois Retina
1235 N Mulford Rd Suite 100
Rockford, IL 61107
(815) 226-4990

Name_____
First Middle Last

Address _____

City/State/Zip _____

Soc. Sec. # _____

Occupation _____

Male _____ **Female** _____

Home Phone _____

Cell Phone _____

Work Phone _____

Birth Date_____ **Age**_____

Employer _____

****

SPOUSE INFORMATION

Spouse name _____

Spouse date of birth _____

Spouse Soc. Sec. # _____

Spouse cell phone # _____

Employer Phone # _____

****

GUARDIAN INFORMATION

Guardian name_____

Guardian date of birth _____

Guardian Soc. Sec. #_____

Guardian cell phone# _____

Employer Phone# _____

Is patient condition related to worker's compensation or an accident?

Yes _____ **No** _____

INFORMATION UPDATE/ PRIVACY DISCLOSURE

Northern Illinois Retina

Name _____Birthdate _____

Address_____Zip_____

Primary phone # _____ is this a home or cell_____
May we leave a message at this number re: a return phone call or your appointment? Yes __ No__

Secondary phone# _____is this a home or cell_____
May we leave a message at this number re: a return phone call or your appointment? Yes __No__

Work phone# _____May we contact you at work? Yes ____ No____

Email _____Insurance _____Secondary _____

Emergency Contact Name _____ Relationship_____

Home Phone _____ Cell Phone _____
Is this someone we can speak to re: Your appointment _____Your health _____Billing _____

Please list other contacts we may speak to if we cannot contact you- very important

Name _____ Relationship _____

Home Phone _____ Cell Phone _____
Is this someone we can speak to re: Your appointment _____Your health _____Billing _____

Name _____ Relationship _____

Home Phone _____ Cell Phone _____
Is this someone we can speak to re: Your appointment _____Your health _____Billing _____

Driver or Transport Service Name _____ Phone _____

Notice of Privacy Practices: Acknowledgment of Receipt We are required by law to ask you to provide written knowledge of receiving this Notice, and ask you to sign here to show that you received this notice.

Signature _____ Date _____

ASSIGNMENT OF BENEFITS

Northern Illinois Retina

DIRECT PAYMENT OF BENEFITS

I authorize release of information to my insurance companies for all insurance claims. I authorize Northern Illinois Retina to act as my agent in assisting to obtain payment from my insurance companies. I authorize any insurance payments to be paid directly to Northern Illinois Retina.

MEDICARE SIGNATURE ON FILE

I request that payment of authorized Medicare benefits be made on my behalf to Northern Illinois Retina for any services furnished to me by the provider. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services ("CMS") and its agents, any information needed to determine these benefits or the benefits payable for related services.

PAYMENT OF ACCOUNT

I am responsible for the timely payment of my account regardless of the status of insurance claims. If my account is sent to the collection agency, I will be responsible for all collection fees. I permit a copy of this authorization to be used in place of the original.

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR THE TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

I have been provided a copy of Northern Illinois Retina's Notice of Privacy Practices and understand that as part of my health care my health care providers maintain records describing my health history, symptoms, examinations, test results, diagnoses, treatment, and any plans for future care or treatment. I understand that my health information may be used and disclosed among my health care providers for treatment purposes and may be used and disclosed by health care providers, insurance companies, or other necessary health plan personnel in order to obtain payment for health care services. I also understand that such entities may use and share health information about me for certain health care operations, such as to assess quality and competency of health care professionals.

I hearby consent to the use and disclosure of protected health information by Northern Illinois Retina and their workforce for treatment, payment, and healthcare operations purposes.

_____ Date _____

Signature of Patient or Power of Attorney

Printed name of Power of Attorney (if applicable) _____

NOTE A copy of P.O.A. document must be provided.

NORTHERN ILLINOIS RETINA

Financial Policy Agreement (FPA)

Thank you for choosing Northern Illinois Retina to treat your retinal condition. We are committed to providing you excellent patient care. Below we have provided an explanation of our Financial Policy Agreement (FPA). Patients must complete the FPA and the Patient Information Form (PIF) prior to receiving any medical care from us.

Please initial and then sign the following:
IMPORTANT REMINDER: WE ARE NOT IN NETWORK WITH MEDICAID OR ANY ILLINOIS PUBLIC AID (IPA) PLANS

_____ 1. If you change to a plan that includes Medicaid, even as a secondary, you will be responsible for anything after your primary pays, and you may need to change doctors to see an in-network provider who takes Medicaid/Public Aid.

_____ 2. Each patient is responsible for his or her own bill. Payment of all insurance co-payments, co-insurances and deductibles are to be paid in full at each visit and prior to any surgery. Your insurance policy is a contract between you and your insurance company. We accept cash, checks and major credit cards (3% surcharge on credit card payments).

_____ 3. As a courtesy, Northern Illinois Retina will file claims to your insurance carrier(s). To accomplish this, you must provide all insurance policy information to our office. If the insurance company(s) that you designate is incorrect, you will be responsible for payment of the visit. **Your bill is your responsibility, whether or not your insurance company pays.**

_____ 4. "Self-pay" patients are required to pay 100% of services rendered at each visit***. Limited insurance or high deductible patients should expect to pay a minimum of $250 on the initial visit and to pay at each visit until deductible is met***. For extended treatments, payment arrangements are available and can be made with the billing staff prior to any medical evaluation, procedure or treatment.

_____ 5. Patient balances unpaid for more than 90 days will incur fees and will be turned over to a third party and/or collection agency. Additional fees will be incurred in the collection of any outstanding balances and may also result in your dismissal from the practice.

_____ 6. As a specialty group, some insurance companies require that an authorization or referral be obtained prior to your visit. **It is your responsibility to know if your insurance requires this.** If your insurance has not given authorization for your visit, it may need to be rescheduled.

_____ 7. A $35.00 fee will be charged on all returned checks.

_____ 8. From time to time, you may ask us to complete various forms (such as disability forms). There is a service fee to complete these forms. Payment is due prior to us giving those completed forms to you. This charge is not covered by your insurance company and offsets the costs and time we incur to complete these forms. Please allow 7 to 14 business days.

_____ 9. ***I understand that failure to maintain a current account with Northern Illinois Retina may result in further non-emergent medical treatment not being provided and/or dismissal from the care of Northern Illinois Retina.***

_____ 10. AUTHORIZATION TO PAY BENEFITS: I authorize and direct said agency or insurance company to pay benefits, or insurance payment made on my behalf, directly to Northern Illinois Retina for professional services rendered. I understand this in no way relieves me of my personal responsibility for paying my responsible portion when a statement is rendered. It is understood that the signing of this form does not prohibit customary monthly billings.

By signing below, I acknowledge receipt of this FPA.

X_____ X_____ Date _____

Signature of patient or responsible party Patient Name- Please Print

_____ NIR Billing Initials _____Scan Date

NORTHERN ILLINOIS RETINA

MEDICAL APPOINTMENT CANCELLATION/NO-SHOW POLICY

Thank you for trusting your medical care to Northern Illinois Retina. When you schedule an appointment with Northern Illinois Retina, we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and **no later than 24 hours prior** to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. **Please see our Appointment Cancellation/ No Show Policy below:**

- Effective immediately any established patient who is receiving **intravitreal injections** who fails to show up or cancel/reschedule an appointment with less than 24-hour notice will be charged a **$85.00** fee. Reschedules will be forgiven for unforeseen/urgent circumstances on a case-by-case basis. After 3 late (less than 24 hours prior notification) cancellations within a one-year period, all future late cancelations (without 24-hour advanced notice) will be charged, regardless of reason.

- Any established patient who is scheduled for a **follow-up exam** with Dr. Fowell and fails to show up or cancels/reschedules an appointment and has not contacted our office with at least a 24-hour notice will be charged a **$110.00** fee.

- Any **NEW patient** who fails to show up for their initial visit without calling more than 24 hours in advance to cancel or reschedule, will not be rescheduled until the No Show Fee of **$160.00** is paid in full.

- The fee is charged to the patient, not the insurance company, and is **due prior to the patient's next office visit**, or the patient will **not** be seen.

- If late cancellations (less than 24-hour notice) continue without an adequate emergency reason, the patient may be dismissed from NIR.

As a **courtesy**, when time allows, we make reminder calls for appointments. **Even if you do not receive a reminder call or message, the above policy remains in effect.** We understand there may be times when an unforeseen emergency occurs, and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our practice manager, who may be able to waive the No Show fee. You may contact Northern Illinois Retina 24 hours a day, 7 days a week at 815-226-4990. Should it be after business hours, you may leave a message. **Messages left within the 24-hour time period are acceptable as 24-hour notice.**

Thank you for your cooperation.

Signature_____

Date_____

Updated 1/4/2024.

Medication List

Name: _____ **Birthdate:** _____ **Date:** _____

CURRENT MEDICATIONS (including vitamins, aspirin & OTC)	**DOSE** (ex: mg)	**DIRECTIONS**	Date Rev'd	Date Rev'd	Date Rev'd

Are you currently taking any blood thinners such as Aspirin, Plavix, or Coumadin? _____

ALLERGIES TO MEDICATIONS (including latex & adhesive tape) AND REACTIONS :

_____

_____

Primary Care Physician: _____ Phone #:_____

Specialist: _____ Phone #:_____

Ophthalmologist: _____ Phone #:_____

Optometrist: _____ Phone #:_____

Northern Illinois Retina

Medical History Questionaire

Name: _____ Birthdate: _____ Date: _____

REVIEW OF SYSTEMS:

Do you currently have or have you ever had any problems in the following areas? If yes, please explain.

Endocrine YES NO _____
Such as: diabetes (on insulin?), or _____
thyroid. If yes, for how long? Last A1C and date: _____

Cardiovascular YES NO _____
Such as: Heart disease or murmur _____

High blood pressure? How long? YES NO _____

Respiratory YES NO _____
Such as: Asthma, emphysema, or _____
tuberculosis. Do you use inhalers? _____

Neurological YES NO _____

Such as: Stroke or Parkinson's _____

Hematological YES NO _____
Such as: Blood disorders, hepatitis, AIDS, or lymph node problems _____ _____

Gastrointestinal YES NO _____
Such as: Stomach ulcers, bowel disorders, or colon cancer _____ _____

Genitourinary YES NO _____
Such as: Kidney failure or prostate cancer (radiated seed implant?) _____ _____

Musculoskeletal YES NO _____
Such as: Arthritis or muscle pain _____

Dermatological YES NO _____
Such as: Skin disorders, psoriasis, or skin cancer _____ _____

REVIEW OF SYSTEMS CONTINUED:

Name: _____ **Birthdate:** _____ **Date:** _____

Allergies YES NO _____
Such as: Seasonal allergies _____

Ears, nose, throat, mouth YES NO _____
Such as: Congestion, cough, or sinus _____

Psychiatric YES NO _____
Such as: Anxiety, depression, confusion, or hallucinations _____ _____

Any chronic illnesses not previously mentioned above? _____

_____

Cancer
Please list any cancers you have or have had in the past. Please include which type of treatments you have had for the cancer._____

_____

Surgeries

List type and date of any surgeries you have had (other than eye surgeries):

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

(Prevnar 13/Pneumovax 23)

Have you ever had: Pneumonia vaccine: YES NO Date: _____

Seasonal Flu vaccine: YES NO Date: _____

Tdap vaccine: YES NO Date: _____

Covid-19 vaccine: YES NO Date: _____

Name: _____ Birthdate: _____ Date: _____

PAST EYE HISTORY:

Have you ever been diagnosed with any of the following?

CATARACT	YES	NO	**MACULAR DEGENERATION**	YES	NO
GLAUCOMA	YES	NO			
DIABETIC RETINOPATHY	YES	NO	**LAZY EYE OR CROSSED EYE**	YES	NO
TOXO OR HISTOPLASMOSIS	YES	NO	**RETINAL TEAR OR DETACHMENT**	YES	NO

Have you had cataract surgery? YES NO

Right eye: When?_____By which doctor?_____

Left eye: When?_____By which doctor?_____

Any other eye surgery or lasers? YES NO

Right eye:
procedure? _____ when? _____ by what doctor? _____
procedure?_____ when? _____ by what doctor? _____

Left eye:
procedure? _____ when? _____ by which doctor?_____
procedure? _____ when? _____ by which doctor? _____

Trauma or injury to either eye? YES NO
If yes please explain: _____

Have you ever had a fluorescein angiogram: YES NO Date done?_____
(pictures of your retina using a dye in your vein)

Any adverse reactions such as hives or nausea? YES NO
Please explain: _____

Name: _____ Birthdate: _____ Date: _____

FAMILY HISTORY:

Please list any family members with the following medical history:
Diabetes……_____
Macular Degeneration…..._____
Glaucoma……..._____
Blindness……..._____
Hereditary illnesses……..._____
Other……_____

SOCIAL HISTORY:

Current occupation?_____ If retired, what was your occupation prior to retirement? _____

Are you currently a smoker? YES NO

How long have you smoked?_____
How much do you smoke per day?_____

If you are a previous smoker, when did you quit smoking?_____
How many years did you smoke?_____ How much did you smoke per day? _____

Do you drink alcohol? YES NO
If yes, how much per day?_____

Do you drive? YES NO
Do you drive at night? YES NO

Have you ever been exposed to anyone with HIV, AIDS, SYPHILIS, OR TB?_____

If yes please explain_____

Have you ever been diagnosed with Covid-19? YES NO
Date of diagnosis: _____Last test date: _____ Results: _____

Physician signature:_____Date:_____

Updated 3/2023

Northern Illinois Retina, LTD
Susan M. Fowell, M.D.
Diagnosis & Surgery of Vitreous & Retina

INFORMATION AND CONSENT REGARDING DILATING EYE DROPS

Dilating drops containing a medication used to enlarge your pupils will be administered to allow the ophthalmologist to see inside your eye.

Please be advised that at each visit one or both of your eyes may be dilated. These drops are necessary to diagnose your condition. It is not possible for your ophthalmologist to predict how much your vision will be affected. Dilating drops blur vision for a length of time which varies from person to person and may make bright lights bothersome. Driving may be difficult immediately after an examination and you may experience a decrease in your ability to judge depth and distance, therefore it is best if you make arrangements to have a driver.

Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare, but you will be monitored and if necessary treated for this condition while here in the ophthalmologist's office.

I hereby authorize Northern Illinois Retina physicians and/or such assistants as may be designated by him/her to administer dilating eye drops at each appointment. I understand the risks and complications described above. I understand that the dilating eye drops are necessary to diagnose my condition.

Patient (or person authorized to sign for patient)

Date

Physician signature