

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 you 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.net. Also, please bring any prescription glasses you may wear or a cop 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 you doctors informed of you evaluation.

Be sure to bring all your insurance cards and 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 or 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

NEW PATIENT INFORMATION

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

Name _____
 First Middle Last

Home Phone _____

Address _____

Cell Phone _____

City/State/Zip _____

Work Phone _____

Soc. Sec. # _____

Birth Date _____ Age _____

Occupation _____

Employer _____

Male _____ Female _____

SPOUSE INFORMATION

GUARDIAN INFORMATION

Spouse name _____

Guardian name _____

Spouse date of birth _____

Guardian date of birth _____

Spouse Soc. Sec. # _____

Guardian Soc. Sec. # _____

Spouse cell phone # _____

Guardian cell phone# _____

Employer Phone # _____

Employer Phone# _____

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

Yes _____ No _____

PRIVACY DISCLOSURE

Northern Illinois Retina

Name _____ Birthdate _____

Phone _____

1. May we leave a message at your residence regarding a return phone call or your appointment? YES _____ NO _____

2. May we contact you at work? YES _____ NO _____

3. Please list 2 people (spouse, friend, or relative) that we may speak to regarding your bill, appointments, eye condition(s), and/or test results :

Name _____ Cell Phone _____

Relationship _____ Home Phone _____

Name _____ Cell Phone _____

Relationship _____ Home 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.

PATIENT 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 hereby 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

MEDICAL APPOINTMENT CANCELLATION/NOSHOW 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 **\$25.00** 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 cancellations (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 **\$50.00** 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 or **\$100.00** 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 hours notice) continue without an adequate emergent 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 _____

Medical History Questionnaire

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):

(Pevnar 13/Pneumovax 23)
Have you ever had: Pneumonia vaccine: YES NO Date: _____
Seasonal Flu vaccine: YES NO Date: _____
Tdap vaccine: YES NO Date: _____

Name: _____ Birthdate: _____ Date: _____

PAST EYE HISTORY:

Have you ever been diagnosed with any of the following?

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

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: _____

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's 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