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 providing you with excellent care. Below is a checklist to help you prepare for your visit.

____ **You will need a driver.** Because of the planned dilation of both eyes, you need to have someone accompany you to your appointment.

____ **Be prepared to spend at least two to three hours with us.** We will gather a full medical history, perform a comprehensive eye examination, and possibly do 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 recommendations for treatment if needed.

____ **Fill out and sign all new patient forms.** Forms are available on our website at www.niretina.com, can be sent to you via mail or email, or picked up at our office. Please mail the forms back or drop them off in advance of your appointment.

****Please bring the following with you to your new patient appointment:

____ Insurance cards- Primary and Secondary

____ Photo ID

____ Prescription glasses or a copy of your eyeglass prescription

____ Medications and eye drops that you are currently using

____ Names and addresses of the physicians that you currently see

If you are unable to keep your appointment, please call us **at least 24 hours prior** to your appointment. Failure to give at least 24 hours' notice of a cancellation will result in a late cancellation or no-show fee of $160.00 which will need to be paid **prior** to rescheduling a new consult appointment.

If you have any questions, please call us at (815) 226-4990.
Our office hours are 8:00am to 4:00pm Monday-Friday

New Patient Information

Name_____ **Home Phone** _____
First Middle Last

Cell Phone _____

Address _____

Work Phone _____

City/State/Zip _____

Soc. Sec. # _____ **Birth Date**_____ **Age**_____

Occupation _____ **Employer** _____

Male _____ **Female** _____

********** **********

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

Name _____ **Birthdate** _____

Address_____ **Zip**_____

Please mark one option

Primary phone #	Home ☐	Cell ☐
May we leave a message at this number re: a return phone call or your appointment?	Yes ☐	No ☐
Secondary phone #	Home ☐	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 ☐

Which method of contact would you prefer for reminders: Text ☐ Call ☐

Email_____

Insurance_____ Secondary_____

Emergency Contact

Name	**Relationship**		
Phone #			
Is this someone we can speak to re:	Appointments ☐	Health ☐	Billing ☐

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

Name	**Relationship**		
Phone #			
Is this someone we can speak to re:	Appointments ☐	Health ☐	Billing ☐

Name	**Relationship**		
Phone #			
Is this someone we can speak to re:	Appointments ☐	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 that you sign here to show that you received this notice.

Signature_____ **Date**_____

ASSIGNMENT OF BENEFITS

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 2026 Financial Policy Agreement (FPA)

Please sign to indicate that you understand the following:

I agree to pay my copay and balance at each visit. Payment of all insurance co-payments, co-insurance and deductible portions are to be paid in full at each visit and prior to any surgery. We accept cash, checks and major credit cards (3% surcharge on credit card payments).

My bill is my responsibility, whether my insurance pays or not. Your insurance policy is a contract between you and your insurance company. As a courtesy, Northern Illinois Retina will file a claim for each visit with your insurance carrier(s) one time and will appeal one time if the claim is denied. After this, the amount that should have been covered by your insurance will be your responsibility to pay Northern Illinois Retina and to contact your insurance to be reimbursed. You must provide up-to-date insurance information to our office. If the insurance information you provide is incorrect or inactive, you will be responsible for payment of the visit.

If I am a self-paying patient- I agree to pay the total of services rendered at each visit. A self-pay discount will apply to all fees paid in full. 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.

Interest will be applied to my balance after 30 days if unpaid. We cannot hold patient balances for extended periods of time. Patient balances unpaid for more than 30 days will incur 3% interest fees each 30 days of nonpayment and will be turned over to a third-party collection agency after 90 days. Additional fees will be incurred in the collection process.

I may need prior authorization from my insurance. Some insurance companies require an authorization or referral prior to your visit. It is your responsibility to know if your insurance requires this. Please bring all referrals to the billing department. We will request prior authorization if needed. If your insurance has not given authorization for your visit, it may need to be rescheduled.

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.

By signing below, I acknowledge receipt of this FPA and agree to the financial responsibilities it lists.

X_____ X_____ _____

Signature of patient or responsible party | Patient Name- Please Print | Date

NIR Billing Initials _____Scan Date _____

Updated 4/6/2026

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.

NORTHERN ILLINOIS retina

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 #:** _____

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):

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Have you ever had:

Pneumonia vaccine: YES NO Date: _____
(Prevnar 13/Pneumovax 23)
Seasonal Flu vaccine: YES NO Date: _____

Tdap vaccine: YES NO Date: _____

Covid-19 vaccine: YES NO Date: _____

NORTHERN ILLINOIS retina

PAST EYE HISTORY:

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

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: _____

NORTHERN ILLINOIS retina

FAMILY & SOCIAL HISTORY

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:_____

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 Signature (or person authorized to sign for patient) Printed Name

_____

Date

_____

Physician Signature