

NEW PATIENT FORM

Milwaukee Avenue Eye Center
7421 N Milwaukee Avenue Niles, IL 60714
Phone: (773) 775-0811 Email:
contactus@maeyecenter.com

PLEASE PRINT CLEARLY

Date: ___/___/___

Name:	_____	Preferred Name / Nickname:	_____
Date of Birth:	___/___/___	Gender (at birth):	Male Female
Address:	_____		
Social Security (for vision insurance):	_____	Email :	_____
Phone Number: (H) ()	_____ - _____	(C) ()	_____ - _____
Preferred Method Of Contact:	<input type="checkbox"/> Home <input type="checkbox"/> Cell	Detailed messages left on voicemail	<input type="checkbox"/> Yes <input type="checkbox"/> No
Primary Care Doctor:	_____	Phone: ()	_____ - _____
IN CASE OF AN EMERGENCY PLEASE CONTACT: Name:	_____		
Phone Number (H) or (C) : ()	_____ - _____	Relationship to You:	_____
I give my permission for the doctor and staff to speak with:			
Name:	_____	Relationship to You:	_____
Name:	_____	Relationship to You:	_____

The patient is responsible for providing correct insurance information and must also provide a copy of insurance cards .

PRIMARY MEDICAL Insurance Name:	_____		
Name of POLICY HOLDER (as on card) :	_____	Policyholder DOB:	___/___/___
Relationship to Patient :	_____		

SECONDARY MEDICAL Insurance Name:	_____		
Name of POLICY HOLDER (as on card) :	_____	Policyholder DOB:	___/___/___
Relationship to Patient :	_____		

VISION INSURANCE : Only our Optmoetrist (OSTOICH & SHEPELENKO are contracted and in-network with VSP & EYEMED. A routine eye exam may be billed as a medical exam if a medical condition is discovered. In that case, your medical insurance will be used and another appointment will be scheduled to use your vision benefits.

Eye Glass/Contact Lens Prescription Received

In compliance with the Federal Trade Commission's Eye Glass prescription/ Contact Lens prescription Rule that went into effect on October 16, 2020 this practice is required to confirm in writing that you received your eyeglass/contact lens prescription.

Authorizations, Acknowledgements, and Consents

Acknowledgment of Receipt of Notice of Privacy Practices: Milwaukee Avenue Eye Center, S.C.(MAEC) is required by law to maintain the privacy of protected health information and to provide patients with notice of our legal duties and privacy practices to protect health information. By signing below, the patient acknowledges receiving a copy of the NOTICE OF PRIVACY PRACTICES by MAEC.

Financial Policy and Disclosure: I hereby authorize payment of insurance and/or third party benefits to be paid directly to MAEC for services rendered. I understand that I am financially responsible for all charges not covered by my insurance, including but not limited to balances resulting from services rendered, regardless of my insurance coverage determination, including if my insurance plan determines the services are not medically necessary or covered, limited to balances resulting from inaccurate insurance information

I authorize MAEC to release any medical or administrative information necessary to process insurance claims. I acknowledge that co-payments, deductibles, and coinsurances are due before services are rendered.

I understand that it is my responsibility to notify MAEC of any insurance changes before services are rendered and to know and comply with my insurance benefits, coverage limitations and referral requirements. I also understand that if a referral for HMO insurance is not on file with our office the appointment will be rescheduled to a different day.

If my account becomes delinquent and is referred to a 3rd party collection agency, I understand a collection fee of 40% will be added to the account. Failure to pay may result in sending you to collections.

Refractions: I understand that a refraction - a vision test that determines your best corrected visual acuity with eyeglasses. It is a measurement that the doctor takes with an instrument called a phoropter. You may hear the doctor ask you , which is better one or 2 . This test is not covered by medical insurance , even if it's medically necessary. The charge is \$50 and agree to pay this fee if not covered by my insurance plan. In compliance with FTC,I have been offered a copy of my eye glass prescription/contact lens prescription, and my questions have been answered.

Self-pay:Self-pay patients are required to pay for their scheduled office visit prior to services being rendered.

No-Show Policy: Dr. Conti patients only: I understand that if I fail to notify the office that I can not come for a scheduled appointment, I will be considered a "no show" and will be charged a \$50 no show fee per occurrence. Scheduling a future appointment with Dr. Conti will require a payment of the no-show fee. Ongoing occurrences may result in dismissal from the practice.

Patient Communication I hereby consent to provide my telephone number(s), including my mobile number(s), so that representatives from MAEC , its successors ,or assignee's can contact me in any manner including but not limited to by manually placing a call, by using an automatic telephone dialing system or an artificial or prerecorded voice, by text or by e-mailing, regarding any matter, including but not limited to my medical treatment, prescriptions, insurance eligibility, insurance coverage, scheduling, billing or collection matters. This consent includes any updated or additional contact information that I may provide. I understand that I will be able to change my preference at any time

Photography: I acknowledge that my photograph may be taken for identification and documentation purposes for my electronic health record and is the property of MAEC unless I withdraw my consent in writing.

Electronic Prescribing: I understand that MAEC may use an electronic prescription system which allows prescriptions and related information to be electronically sent between MAEC and my pharmacy. I have been informed and understand that MAEC using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to MAEC to see this health information. **Consent for Treatment:I consent to receive medical care and treatment from MAEC and it's providers. Treatment for MINOR CHILDREN : I understand minor children patients must be accompanied by parent or legal guardian.**

The undersigned certifies that s/he has read (or have had read to me) the foregoing, understands it, accepts its terms, and has received a copy of. I hereby agree to all terms and conditions set forth above and understand that any sections of this consent that I do not consent to, I have struck through and initialed the section that does not have my consent or permission.

Signature of Patient or Parent/Legal Guardian/Authorized Representative

Relationship to Patient, if applicable

Date of Signing

Witness to Signature

Eye Health History

Please **check** all applicable

Blurred Vision - Distance	<input type="checkbox"/> Yes <input type="checkbox"/> No	Flashes of Light	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blurred Vision - Near	<input type="checkbox"/> Yes <input type="checkbox"/> No	Floaters / Spots	<input type="checkbox"/> Yes <input type="checkbox"/> No
Burning Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lazy Eye	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Retinal Detachment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dry Eye(s)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Macular Degeneration	<input type="checkbox"/> Yes <input type="checkbox"/> No
Discharge	<input type="checkbox"/> Yes <input type="checkbox"/> No	Loss of Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No

Medical History

Please **CHECK** all applicable

<input type="checkbox"/> Ankylosing Spondylitis	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Lupus	<input type="checkbox"/> Rosacea
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Headaches	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Seizures
<input type="checkbox"/> Atrial Fibrillation	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Parkinson's Disease	<input type="checkbox"/> STD
<input type="checkbox"/> Diabetes	<input type="checkbox"/> HIV / AIDS	<input type="checkbox"/> Prostate Disorders	Other: _____
Cancer: _____	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Rheumatoid Arthritis	Other: _____

Allergies

<input type="checkbox"/> No Known Allergies

Eye & General Surgeries

<input type="checkbox"/> No surgeries	
	Year:
	Year:
	Year:
	Year:

Primary Doctor Information

Primary Doctor (First & Last Name): _____ Phone Number: () _____ - _____