ZIBUTE G. ZAPARACKAS, M.D.
PAUL A. KNEPPER, M.D., PH.D.
YURI KIM KERN, M.D.

Diseases and Surgery of the Eye

NEW PATIENT REGISTRATION

Please fill out the enclosed forms and bring them with you to your appointment. A new patient examination requires 60 to 90 minutes.

IMPORTANT INSURANCE COVERAGE INFORMATION

Most medical insurance companies do not pay for examinations that do not have a medical diagnosis. We are only in network with medical insurance, not vision, HMO or Medicaid plans.

This includes:

- Normal ocular exams: no medical concerns, failed school eye exams, screenings, etc.
- Refractive errors: nearsightedness (myopia), farsightedness (hyperopia), astigmatism, etc.
- Family history of eye disorders

Please note that fees for these services range from $350-$500 depending on services rendered. Your visit will still be submitted to your insurance company before you receive a statement.

If your child does NOT have a medical diagnosis you may receive a bill for the full examination fee.

*****We will gladly provide you with a school form at your visit. If you need a duplicate after your visit, there is a $15 fee.*****

150 East Huron Street, Suite 1000 Chicago, IL 60611 Phone #: (312) 337-1285 Fax #: (312) 337-1452

OFFICE LOCATION & PARKING

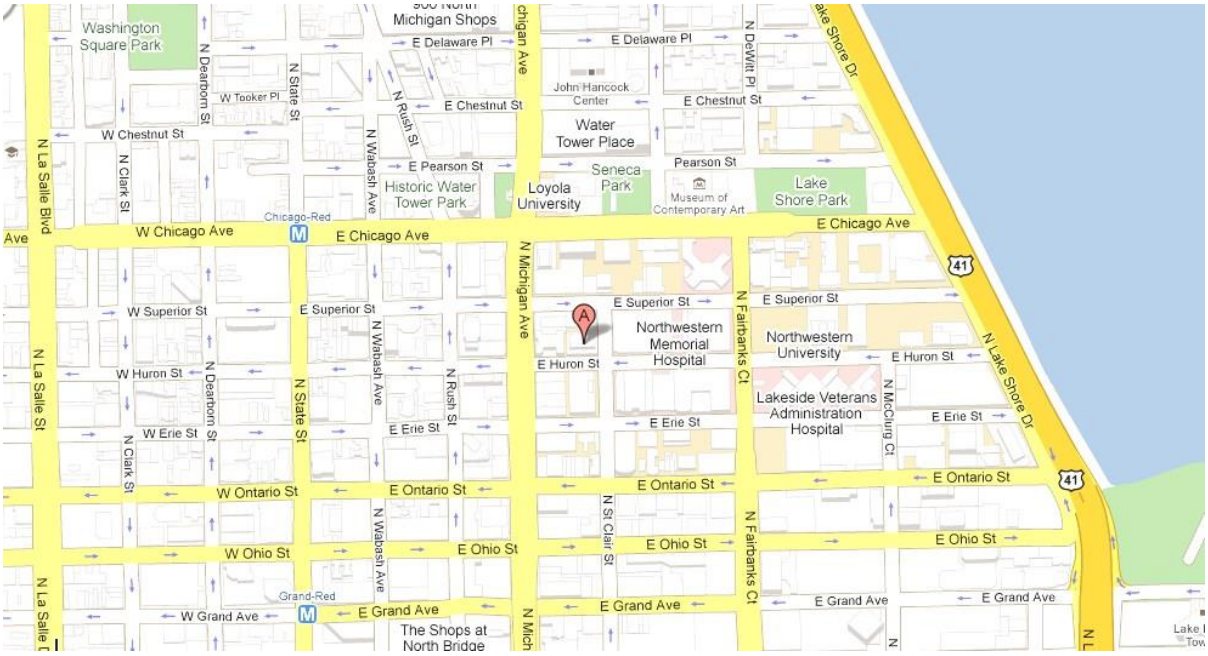
Our office is located in the Hampton Inn & Homewood Suites Offices on the 10th floor:

150 East Huron Street
Suite 1000
Chicago, IL 60611
USA

We offer discounted patient parking for Northwestern Self Park, located at:

222 East Huron Street
Chicago, IL 60611
USA

You can enter the parking garage from either Superior Street or Huron Street. Validated parking is **$13.00** and is effective for 4 hours. All parking stickers must be paid for in **CREDIT OR DEBIT CARD** at our office at the time of your appointment.



PATIENT REGISTRATION FOR CHILDREN

ALL FIELDS MUST BE COMPLETED

Date: _____

Patient Name: _____
Last First MI

Birthdate: _____ Social Security #:_____ (Optional) Sex: Male / Female

Address: _____
Apartment/Unit City State Zip Code

Primary Care Physician: _____ Phone #: (___) _____

Referring Physician: _____ Phone #: (___) _____

PARENT INFORMATION (List parent 1 as primary policy holder for insurance)

PARENT 1: _____
Last First MI

Address: _____
Apartment/Unit City State Zip Code

Occupation: _____ Employer: _____

Email: _____ Home Phone #: (____) _____

Cell Phone #: (____) _____ Work Phone #: (____) _____

Birthdate: _____

PARENT 2: _____
Last First MI

Address: _____
Apartment/Unit City State Zip Code

Occupation: _____ Employer: _____

Email: _____ Home Phone #: (____) _____

Cell Phone #: (____) _____ Work Phone #: (____) _____

Birthdate: _____

PRIMARY INSURANCE

INSURANCE COMPANY: _____

POLICY HOLDER: _____
Last First MI

Phone#: (____) _____ Birthdate: _____ Sex: Male / Female

Patient's Relationship to Insured: Self / Spouse / Child / Other _____

HEALTH HISTORY

Date: _____

Patient Name: _____ Birthdate: _____

Last First MI

1. Do you have any drug/medication allergies? _____
2. Please list any medications you are taking: _____
3. Have you ever been hospitalized? _____
4. Have you needed emergency treatment?_____
5. Have you ever had surgery? _____
6. Do you have any ongoing medical concerns? _____
7. Are you in good health? _____
8. Do you wear glasses or contacts? _____

HEALTH HISTORY *(PLEASE MARK EACH BOX **INDIVIDUALLY**)*			**OCULAR HISTORY** *(PLEASE MARK EACH BOX **INDIVIDUALLY**)*		
	Yes	**No**		**Yes**	**No**
Eye/Vision Problems			Headaches		
Ear/Hearing Problems			Blurry Vision		
Dental Problems			Redness		
Blindness			Drainage/Discharge		
Lazy Eye			Crossing/Drifting		
Thyroid Problem			Squinting		
Fainting Spells			Light Sensitivity		
Urine/Kidney Infections			Dry Eyes		
Wheezing or Asthma			Double Vision		
Heart Condition/Heart Murmur			Dizziness		
Anemia/Blood Problems			Itchy or Burning		
Seizures/Convulsions/Epilepsy			Trauma (please describe)		
Recurrent Skin Rash/Eczema					
Stomach or Bowel Problems			Additional Info or concerns:		
Diabetes					
Hay Fever/Allergies					
Fractures/Bone Problems					
Cancer					
High Blood Pressure					
Use of Tobacco Products?					
Use of Alcohol?					

Completed by: _____ Relationship to Patient: _____

OFFICE USE ONLY

Notes:

Reviewed By:

150 East Huron Street, Suite 1000 Chicago, IL 60611 Phone #: (312) 337-1285 Fax #: (312) 337-1452

Credit Card and Payment Policy Effective 2024

Do not return this page via email, please complete in office or bring in completed

I hereby acknowledge the following payment policies for the office of Drs. Zaparackas, Kern and Knepper:

1) Payment of coapys, patient portions and balances due are expected at the time services are rendered.
2) We will submit a claim for services rendered to your insurance company. When an insurance company is required to pay for services rendered, **you are only responsible for what is considered the patient portion of the claim.**
3) We have a 24-hour cancellation notice for all appointments. If an appointment is cancelled with less than 24-hour notice, you will be charged $50 per appointment cancelled without adequate notice.
4) Our office will send a paper statement when requested, however, your insurance company will provide you with an Explanation of Benefits (EOB) which will reflect the patient portion due. You will also receive electronic statements from Tebra. **Your credit card will be charged for the remaining patient responsibility within 30 days from the date of response from your insurance company. If you wish to pay using a different method, it must be done prior to the 30 day window.**

Our practice uses Tebra for patient billing, emails with notifications about balances due will come from Tebra.

Credit Card Authorization:

The credit card information will be stored in Tebra, a fully secure, HIPAA complaint and PCI certified software system. I hereby authorize the practice to charge my credit card for outstanding balances, patient portions and any cancellation fees owed to the practice, as provided in this payment policy.

Name of Patient: _____

DOB: _____

Type of Card: VISA Mastercard AMEX Discover

Card Number: _____

Expiration Date: _____ Security Code: _____

Billing address: Check here if same as patient primary mailing address ☐

Or complete address below:

_____

_____

Name of Cardholder: _____

Authorized Signature: _____ **Date:** _____

ZAPARACKAS & KNEPPER, LTD.
AUTHORIZATION FOR FINANCIAL RESPONSIBILITY

Date _____

I, acting for myself or on behalf of _____, authorize the release of any medical information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
I understand that I remain liable for payment of all medical services rendered by Zaparackas & Knepper, Ltd.

_____
Initial

I understand that I am responsible for knowing the terms and conditions of my individual insurance plan. Due to the vast number of different insurance plans, Zaparackas & Knepper, Ltd. personnel are not responsible for informing me of which tests or procedures are covered benefits under my individual insurance contract. I am responsible for all non-covered portions, including but not limited to any deductibles, co-payments, co-insurance, non-covered services, out of network amounts, contract limits, or other fees specifically assigned by my plan as patient responsibility.

I understand that in order to ensure my claim is processed correctly, Zaparackas & Knepper, Ltd. will need a copy of my current insurance card (written or typed information will not be sufficient). Patient demographics are required to be updated annually. I will assist by completing my forms fully each time, and by signing and dating each new form. Failure to provide updated and accurate information may result in billing errors or delays.

I understand that if I do not have my insurance card on the date of service, payment for my visit will be due at the time of service. Zaparackas & Knepper, Ltd. will be more than happy to give me a receipt that I can submit to my insurance carrier for reimbursement.

I understand that all co-pays and past balances are due at the time services are rendered. Payments can be cash, personal checks, Visa, MasterCard, American Express and Discover. Returned checks, balances older than 90 days and failure to pay patient balances as promised may be subject to collection action.

_____
Initial

I understand that most medical insurance companies do not pay for examinations that do not have a medical diagnosis. This may include normal ocular examinations such failed school eye exams and school screenings, refractive errors, family history of eye disorders, or anything else my insurance company deems routine.

I understand that if my child's diagnosis is normal, payment is due at the time services are rendered. If my insurance company covers my child's examination a refund check will be issued to me.

_____
Initial

If I do not have health insurance, I understand that I am personally responsible for all medical services rendered by Zaparackas & Knepper, Ltd. at the time of service.

_____
Initial

My signature constitutes acknowledgement and acceptance of this policy.

_____ _____ _____
Signature **Print** **Date**

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NOTICE OF REFRACTION FEE
EFFECTIVE APRIL 1, 2023

I understand and have been informed that a “REFRACTION” is a separate part of the exam required to determine if a refractive error exists and/or prescribe glasses. It is often considered not a part of medical care and may be refused by the insurance company even when the rest of the exam is covered. I understand and accept that I may be responsible for this fee ($60.00) out of pocket and agree to pay as indicated.

Patient Name (Printed) Date

Signature of Responsible Party

Printed name of Responsible Party

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

USES AND DISCLOSURES

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of Zaparackas and Knepper, Ltd. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Referring Physicians. Your health information may be forwarded to your primary care and/or referring physician in order to ensure continuity of care.

Law enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

ADDITIONAL USES

Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Information about treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition.. We may also send you information describing other health-related products and services that we believe may interest you.

INDIVIDUAL RIGHTS

You have certain rights under the federal privacy standards. These include:

- the right to request restrictions on the use and disclosure of your protected health information
- the right to receive confidential communications concerning your medical condition and treatment
- the right to inspect and copy your protected health information

- ❖ the right to amend or submit corrections to your protected health information
- ❖ the right to receive an accounting of how and to whom your protected health information has been disclosed
- ❖ the right to receive a printed copy of this notice

ZAPARACKAS AND KNEPPER, LTD. DUTIES

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

RIGHT TO REVISE PRIVACY PRACTICES

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

REQUESTS TO INSPECT PROTECTED HEALTH INFORMATION

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the front desk receptionist. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

COMPLAINTS

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Zaparackas and Knepper, Ltd.
150 East Huron Street
Suite 1000
Chicago, IL 60611
USA

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated against for filing a complaint.

EFFECTIVE DATE

This Notice is effective on or after June 20, 2012.

Acknowledgement of Receipt of Notice of Privacy Practices

I have received, read and understand the *Notice of Privacy Practices* for Zaparackas and Knepper, Ltd. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions but if you do agree then you are bound to abide by such restrictions.

_____

Patient Name

_____

Signature of Patient

_____

Date

_____

Signature of Patient Representative
(Required only if the patient is a minor or an adult who is unable to sign this form)

_____

Relationship of Patient Representative to Patient