

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

We are a fee for service practice. We will collect in full at the time of service. As a courtesy, we will submit a claim to your insurance carrier and they will reimburse you directly. We can only submit claims to commercial insurance plans, and cannot submit claims to Medicare or Medicaid.

Fee-For-Service Pricing

Service	Price Range	Insurance Reimbursement Estimate
New Patient Examination	\$300-\$350	\$140-\$350
Established Patient Examination	\$200-\$250	\$80-\$250
Ancillary Testing/Imaging (photography, motility examination, refraction)	\$25-\$75	\$12-\$75

Our physicians will only provide ancillary testing when it is medically necessary for diagnosis and treatment. We will do our best to provide more detailed estimates prior to appointments if requested.

Insurance reimbursement estimates are approximate only and vary depending on plan limits, deductible status, and eligibility.

*****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.*****

OFFICE LOCATION & PARKING

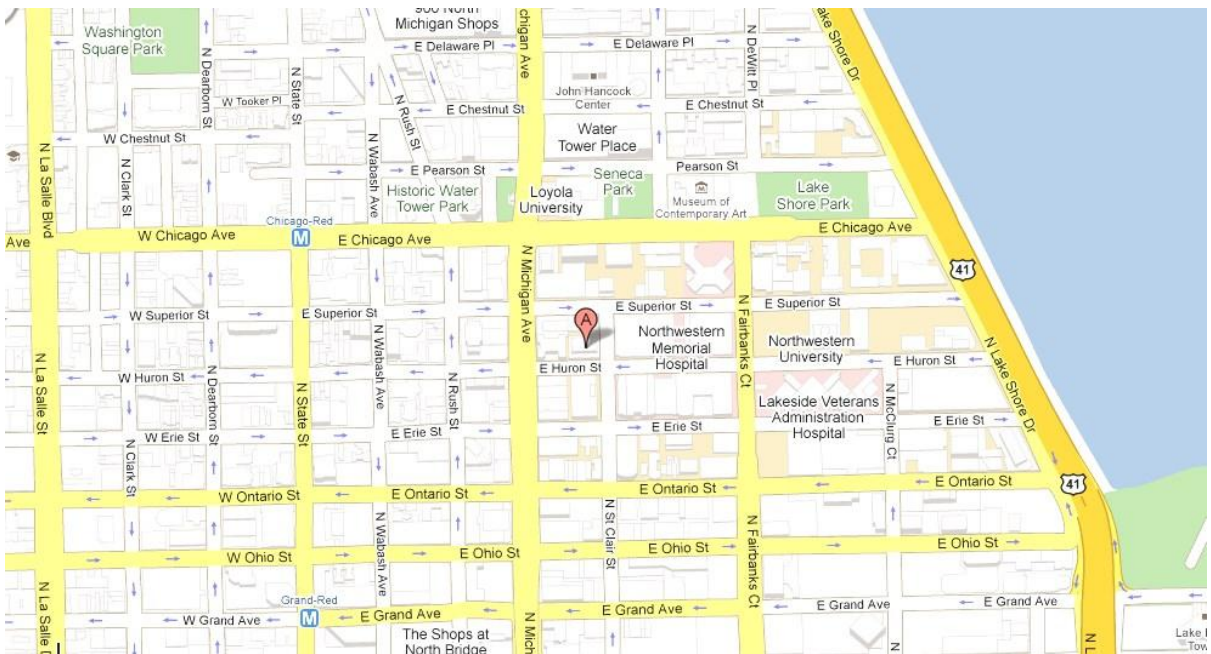
Our office is located in the Hampton Inn & Homewood Suites Offices on the 10th floor:

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.



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 <i>(PLEASE MARK EACH BOX INDIVIDUALLY)</i>			OCULAR HISTORY <i>(PLEASE MARK EACH BOX INDIVIDUALLY)</i>		
	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:

ZAPARACKAS & KNEPPER, LTD.
AUTHORIZATION FOR FEE FOR SERVICE

Date _____

I, acting for myself or on behalf of _____, authorize the release of any medical information necessary to process claims submitted to my insurance carrier by the providers. I acknowledge that reimbursement from my insurance carrier will be provided to me directly.

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.

My signature constitutes acknowledgement and acceptance of this policy.

Signature

Print

Date

Acknowledgement of Receipt of Notice of Privacy Practices

I have received, read and understand the *Notice of Privacy Practices* for Zapparackas 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

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.