EYE CARE CENTER OF LAKE COUNTY, LTD.

PATIENT REGISTRATION FORM
(PLEASE PRINT)

FIRST NAME:_____MIDDLE:_____LAST: _____

ADDRESS:_____CITY:_____ST:_____ZIP: _____

HOME PHONE:_____CELL:_____EMAIL:_____

DATE OF BIRTH:____/____/_____SOCIAL SECURITY:_____OCCUPATION: _____

MARITAL STATUS: □ single □ married □ widow □ divorced STUDENT STATUS: □ full-time □ part-time

EMERGENCY CONTACT INFORMATION		
NAME:	RELATIONSHIP:	PHONE:
NAME:	RELATIONSHIP:	PHONE

In compliance with the Affordable Care Act, we are requesting the following information:

RACE: □ WHITE □ AFRICAN AMERICAN □ ASIAN □ AMERICAN INDIAN/ALASKAN NATIVE □ OTHER: _____
ETHNICITY: □ HISPANIC/LATINO □ NON-HISPANIC/NON-LATINO
PREFERRED LANGUAGE: □ ENGLISH □ SPANISH □ OTHER: _____
DO YOU REQUIRE LANGUAGE ASSISTANCE? □ YES □ NO

I HAVE RECEIVED A COPY OF THE NONDISCRIMATION AND LANGUAGE ASSISTANCE POLICY	**Initials:**
I HAVE RECEIVED A COPY OF THE HIPAA POLICY	**Initials:**
I HAVE RECEIVED A COPY OF THE FINANCIAL POLICY	**Initials:**
I HAVE RECEIVED A COPY OF THE ELECTRONIC COMMUNICATION POLICY	**Initials:**

Name of Primary Care Physician:_____**Phone:**_____

Pharmacy:_____**Location:**_____**Phone:**_____

INSURANCE INFORMATION: PRIMARY		**SECONDARY**
Name of insurance carrier:		**Name of insurance carrier:**
Name of insured:		**Name of insured:**
Date of birth: SSN:		**Date of birth: SSN:**
Phone number on back of card:		**Phone number on back of card:**
Member ID number:		**Member ID number:**
Group Number:		**Group Number:**
Relationship to patient:		**Relationship to patient:**

I authorize payment of Medicare and/or insurance benefits to Eye Care Center of Lake County, Ltd. for services or materials provided to me. I understand that I am responsible for any balances not paid by my insurance (non-covered services, copay, deductibles or coinsurance). I authorize the release of information to my insurance in order to obtain benefits and/or payment.

_____/_____
Patient's signature or Parent/Legal Guardian's signature if patient is a minor (under the age of 18) **Date**

If signed by parent/legal guardian, please print name: _____

Form updated 01/01/2018 Reviewed by staff member:_____Date: _____

Eye Care Center of Lake County, Ltd

Patient Name: _____

Patient's date of birth: _____

Communication /Office Protocols/Financial Policy Effective 01-01-2026

Our practice believes that a good physician/patient relationship is based upon understanding and communication.

I have received a copy of the Nondiscrimination and language assistance policy.

Preferred language: [**] English [ ] Spanish [ ] Other :_____Do you require language assistance:** [ ] NO [ ] YES

Electronic Communication is available, and we recommend you enroll (Patient Portal/Demand Force). I have received a copy.

Medical records release: a written request is required prior to releasing Protected Health Information (PHI)-forms are available.

We will charge the standard fee that is determined by the State of Illinois for medical record copy/release.

HIPAA: I have received a copy of the HIPAA policy.

Treatment of a Minor: For the first visit, a parent or legal guardian must accompany a minor to our office. Follow-up visits: a written letter from a parent(s) and/or legal guardian must be presented if a minor (under 18) is to be seen without the parent or legal guardian present. The person accompanying the minor must present a photo id. The patient is responsible for presenting any insurance cards, copayments, deductibles for the services rendered. **The person that accompanies a minor is responsible for payment**.

Our practice participates with a variety of medical insurance plans and vision plans

Please contact our business office if you have any billing questions or concerns. Specific questions regarding your insurance benefits or coverage will be redirected to your insurance member services (the number on the back of your insurance card).

1) Bring your insurance(s) cards to **every visit and government issued ID.** We will submit to the insurance carrier(s) you present at the time of service.

2) If you have insurance that we are not contracted with, **you are responsible for payment in full at the time services are rendered.**

3) If you are unable to pay, it is your responsibility to inform us prior to the visit.

4) If your insurance plan requires a referral, **we must have the referral available** at the time of visit or your visit may be rescheduled, or you may be responsible for payment.

5) Any copayments, deductibles or coinsurance amounts must be paid at the time of service. We accept cash, credit cards or check. Your check may be processed as an ACH (automatic clearinghouse) transaction.

Vision Plans and Optical Services: We will bill optical materials (glasses and contact lenses**) to vision plan(s) which we have a contract with** based on your eligibility. If you do not have a covered-contracted vision plan, then you will need to pay for the materials in full at the time of service and submit the bill to your insurance for any reimbursement. This is an estimate and not a guarantee of payment.

Glasses- see our optical policy for frame warranties, remakes, payment, restocking fee, shipping fee. Refraction fee must be paid in full prior to the release of glasses prescription. A copy of your glasses prescription will be provided for your personal information only.

Contact Lens Examination and Fitting Services: are separate from the "Routine Eye Exam" or "Well Vision Exam" and will be billed in addition to your "Routine Eye Exam" should you choose to or need to wear contact lenses. You may have coverage for this service if you have a vision plan, your copayment or coinsurance responsibility is due at the time of service. All contact lens exam/fitting fees must be paid in full prior to the release of the contact lens prescription. A copy of your prescription will be provided to you for informational purposes only. All Contact Lens Verifications should be faxed to 847-244-5122.

Return Check or Credit Card Fee: Any payment made by check or credit card that does not clear our bank account will result in a $50.00 return fee and will be added to your account.

Past Due Balance/Collection: All open/collection accounts are to be paid before any additional services are rendered.

No Show or appointments cancelled with less than 24 hours' notice: a fee of $75.00 will be added to your account.

Credit Card on file: I am permitting you to keep my credit card on file only to be utilized if I fail to meet the agreed-upon terms of this policy. I also understand you will notify me each time before you charge my card.

By signing below, I acknowledge receiving and understanding all the above. All questions have been answered to my satisfaction.

Patient or Parent/Guardian (if minor) signature: Date:

Printed name of person signing this form if not the patient:

EYE CARE CENTER OF LAKE COUNTY, LTD.

Patient name:_____ **Date of birth**: _____

PATIENT COMMUNICATION FORM (HIPAA)

It is the office policy of Eye Care Center of Lake County, Ltd. not to release confidential medical information regarding your treatment to family members or friends, except for (i) parent/legal guardian, (ii) other person authorized by patient, (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless your object, that person is entitled to receive information regarding your treatment),(iv) in emergency situations, or (v) other as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you anticipate that you will need or want your medical information to be provided to family members, friends, or caretakers/babysitters, please indicate that below, so that we may best serve you. By signing below, you authorize the following people to receive information regarding your treatment or care. If you wish to add names later on or delete names, please confirm this in writing.

□ Spouse (name):_____ Phone: _____

□ Mother (name):_____ Phone: _____

□ Father (name):_____ Phone: _____

□ Adult Child (name):_____ Phone: _____

□ Adult Child (name):_____ Phone: _____

□ Adult Child (name):_____ Phone: _____

□ Other:_____ Phone: _____

□ School:_____ Phone: _____

□ Employer:_____ Phone: _____

Name of contact/person: _____

_____ _____

Patient's signature (if minor under the age of 18 then parent/legal guardian) Date signed

_____ _____

Print name of person signing form Relationship to patient if not self

Form updated 01/01/2026

Eye Care Center of Lake County, Ltd (ECCLC)

Electronic Communication-Patient Portal User Agreement and Informed Consent

Name._____Date of birth_____

Address._____City _____ST____ Zip— — — — —

Home- - - - - - - - - - - - Cell_____Email,_____

Patient portal basics

Eye Care Center of Lake County, Ltd (ECCLC) understands the need for communication between health care professionals and patients. ECCLC is committed to providing patients and other authorized personnel the ability to use a secure and confidential patient portal that provides the following functionality:

1. Access to request appointments
2. Receive appointment reminders
3. Access important health information from your medical record
4. View medication lists and request prescription refills
5. Obtain educational information
6. Maintain account information {user name, password, access privileges and email address)
7. Pay your bill online
8. Secure communication with health care professional

The NextGen Patient Portal and/or DemandForce utilize technology to deliver secure communications between patients and ECCLC.

The term "patient portal" refers to the part of ECCLC's information system that provides access to patients' health information and allows for secure communication, including prescription, referral and appointment requests.

"Electronic Communication" means e-mail or text messaging with patients outside of a patient portal and/or DemandForce which are both HIPAA compliant.

Patient portal policy

The following policies and limitations apply to the use of ECCLC's patient portal and/or DemandForce:

1. Patient portal communication is not for emergency purposes. If you are having an emergency, dial 911 or go to the nearest hospital.
2. Correspondence via patient portal is supplemental to physician/patient encounters. ECCLC will not provide patient portal based diagnosis and treatment
3. Other "electronic communication" with the health care professional, such as non-patient portal email or text messaging is prohibited.
4. Communications sent via patient portal must be courteous, respectful, appropriate, fact-based and truthful.
5. Communications should be responded to within three business days. You agree not to use this portal if you need a response sooner or on an urgent basis. If your need is urgent you must contact the practice d i r e c t l y .
6. You agree not to share your password with anyone and that you are solely responsible for protecting your password.
7. You agree that access to the site is provided on an "asis available" basis and that our practice cannot guarantee you will be able to access the portal at any time. Internet based communications are inherently insecure since no technology guarantees privacy or security of information sent over the internet. You agree to use caution when providing information via this portal, and acknowledge that keeping messages secure is your responsibility.

Conditions of participation:

Access to NextGen Patient Portal and DemandForce is restricted to the above-named patient. This service is optional, and we reserve the right to suspend or terminate the service and/or your access to it at any time. If the practice suspends this service, you will still have access to copies of your medical records and other health information, upon written request. The patient acknowledges that he/she agrees to comply with the ECCLC Patient Portal Policy outlined above.

□ I hereby **request to enroll** in the electronic communications using Patient Portal and/or DemandForce.

□ I hereby **decline to enroll** in the electronic communications using Patient Portal and/or DemandForce.

Patient's Signature:_____ Date:_____

ECCLC Patient Portal form reviewed 1-1-2018

Eye Care Center of Lake County, ltd.
Phone: 847-244-1657 Fax: 847-244-5122

Pediatric Medical History Form
(please print)

Today's date: _____

Patient's name: (preferred or nickname):	**Date of birth:**

Mother's name	**Date of birth:**
Father's name	**Date of birth:**
Pediatrician	**Phone:**

Student status: **[ ] full time [ ] part-time Name of School:**

Social History

Smoker [ ] No [ ] Yes [ ] cigarettes # per day [ ] e-cigerattes [ ] other
Alcohol [ ] No [ ] Yes how much [ ] daily [ ] occasional/social
Caffiene [ ] No [ ] Yes [ ] coffee [ ] tea [ ] soda [ ] other

Allergies to Medication: [ ] No [ ] Yes

Medication name	***Reaction***

Name of Medication(s)- [ ] none	**Dose/strength**	**Instructions**

Vision questions

Any problems with distance vision	[ ] No	[ ] Yes	Problems with near vision	[ ] No	[ ] Yes
Have you worn glasses	[ ] No	[ ] Yes	Have you worn contacts	[ ] No	[ ] Yes
Do you wear glasses	[ ] No	[ ] Yes	Do you wear contacts	[ ] No	[ ] Yes
Do you drive	[ ] No	[ ] Yes	Problems driving at night	[ ] No	[ ] Yes

Eyes (current symptoms or concerns)

Amblyopia (lazy eye)	[ ] No	[ ] Yes	Foreign Body	[ ] No	[ ] Yes
Blurred Vision	[ ] No	[ ] Yes	Glare/light sensitivity	[ ] No	[ ] Yes
Burning	[ ] No	[ ] Yes	Mucous discharge	[ ] No	[ ] Yes
Chronic infection of eye	[ ] No	[ ] Yes	Occasional tearing	[ ] No	[ ] Yes
Chronic infection of eye lid	[ ] No	[ ] Yes	Pain or soreness	[ ] No	[ ] Yes
Distorted Vision	[ ] No	[ ] Yes	Sandy or gritty feeling	[ ] No	[ ] Yes
Double Vision	[ ] No	[ ] Yes	Sties, Chalazion	[ ] No	[ ] Yes
Dryness	[ ] No	[ ] Yes	Strasbismus	[ ] No	[ ] Yes
Excessive tearing/watering	[ ] No	[ ] Yes	Tired eyes	[ ] No	[ ] Yes
Fluctuating visual acuity	[ ] No	[ ] Yes	Other:	[ ] No	[ ] Yes

Patient Name **Date of birth:**

Past Surgical History-Procedure	Date	Surgeon
Past Hospitalizations-Reason	**Date**	**Hospital**

Past Medical and Family History (if yes indicate with "X", if deceased indicate with "D" and age at death

Condition/Disease (circle if indicated)	Self	Sibling		Mother	Father	Grand-Mother	Grand-father
Arthritis (general)							
Bleeding Disorder/disease							
Blindness							
Cancer							
Cataract							
COPD (Asthma)							
Corneal disease							
Diabetes							
Insulin Dependent							
Dermatology disorders (skin problems-eczema, psorasis etc)							
Glaucoma							
Heart Problems (irregular heart beat, heart valve problems, highblood pressure, heart attack)							
Kidney Problems							
Liver Problems							
Lupus							
Macular degeneration							
Neurological (seizures, MS etc)							
Psychological (mental illness)							
Retinal detachments							
Rheumatoid arthritis							
Sjogren's syndrome							
Stroke/TIA							
Thyroid (Hyper or hypo)							

List any medical conditions not addressed above or your feel are important

Signature: **Date:**

Form completed by: **[ ] mother [ ] father [ ] legal guardian**

Form updated 2018 Reviewed by: