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 1-14-2019

Our practice firmly 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/DemandForce). 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 first time 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. **Ultimately the person that accompanies a minor is responsible for payment**.

Our practice participates with a variety of medical insurance plans and Vision Service Plan (VSP).

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 Service Plans and Optical Services: We will bill optical materials (glasses and contact lenses**) to Vision Service Plan (VSP)** based on your eligibility. If you do not have VSP 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 VSP; 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 Fee: Any payment made by check that does not clear our bank account will result in a $30.00 return check fee and will will be added to your account.

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

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.
P: 847-244-1657 F: 847-244-5122

Adult Medical History Form (2020)

Name: _____

Date of birth: _____ **Last four digits of SSN:** _____

Today's date: _____

Preferred Pharmacy: _____

Pharmacy phone number: _____

Allergy to latex? [ ] no [ ] yes

Primary care physician: _____

Allergies to medication? [ ] no [ ] yes
(Medication name/reaction)
_____/_____
_____/_____
_____/_____
_____/_____

Medication list (name of medication, dosage, instructions) [ ] see list
_____
_____
_____
_____
_____

Social history

Tobacco use: check all those that apply:
[ ] Never smoker
Year started smoking: _____
[ ] current every day smoker, # of packs per day___
[ ] current occasional smoker, # per day_____
[ ] former smoker, year quit: _____
[ ] Vaping [ ] no [ ] yes, date start:_____
quit date**:** _____

Alcohol use: check all those that apply:
[ ] never [ ] occasional [ ] daily

Do you live alone? [ ] yes [ ] no
if no, who do you live with: _____
Do you drive? [ ] Yes [ ] no
Do you have problems with night vision? [ ] yes [ ] no
Do you have visual difficulty when driving? [ ] yes [ ] no
Do you wear glasses? [ ] yes [ ] no
If yes, how long have you had the current pair? _____
Have you ever tried to wear contacts? [ ] yes [ ] no
Do you currently wear contacts? [ ] yes [ ] No

Eye symptoms

Loss of vision	[ ] yes [ ] no	**Dryness**	[ ] yes [ ] no	**Foreign body sensation**	[ ] yes [ ] no
Blurred vision	[ ] yes [ ] no	**Mucous discharge**	[ ] yes [ ] no	**Chronic eye infection**	[ ] yes [ ] no
Distorted vision	[ ] yes [ ] no	**Redness**	[ ] yes [ ] no	**Chronic eyelid infection**	[ ] yes [ ] no
Loss of side vision	[ ] yes [ ] no	**Sandy or gritty feeling**	[ ] yes [ ] no	**Sties, Chalazion**	[ ] yes [ ] no
Double vision	[ ] yes [ ] no	**Itching**	[ ] yes [ ] no	**other**	[ ] yes [ ] no
Glare/light sensitivity	[ ] yes [ ] no	**Excess tearing**	[ ] yes [ ] no	_____	
Fluctuating vision	[ ] yes [ ] no	**Tired eyes**	[ ] yes [ ] no	**Keratoconus** Right Left	[ ] yes [ ] no

Past surgical history

Date	Procedure	Surgeon	Facility/location

Anesthesia: Have you ever had problems with anesthesia? [ ] no [ ] yes
If yes, explain: _____

Past hospitalizations

Date	Reason	Name of hospital

Adult Medical History Form updated 1-1-2020
updated

Reviewed by: _____ [ ] reviewed no changes [ ]

Patient name: _____ Date of birth: _____

Past medical and family history (please indicate yes with an "x") (if Deceased indicate with "D" and age of death)

DISEASE CONDITION	Self	Father	Mother	Sibling	Child	Grand Parent		DISEASE/ CONDITION	Self	Father	Mother	Sibling	Child	Grand Parent
Abnormal heart rhythm								Headaches [ ] migraines						
AIDS								Heart valve problem						
Anemia								Hepatitis						
Angina								**High blood pressure**						
Arthritis								High Cholesterol						
Asthma								HIV						
Bleeding disorder								Kidney failure						
Blindness								Kidney stones						
BPH								Liver Problem						
Cancer								**Lupus**						
Cardiomyopathy								**Macular degeneration**						
Cataract								Mental disorder						
Clotting disorder								MI (heart attack)						
Colitis								Osteoporosis						
COPD (chronic obstructive pulmonary disease)								**Psoriasis**						
Corneal disease								**Retinal detachments**						
Diabetes Mellitus [ ] type 1 [ ] type 2								**Rheumatoid arthritis**						
Insulin Dependent								Seizures						
Eczema								Sickle cell anemia						
Emphysema								**Sjogren's syndrome**						
Endocrine problem								Stroke or TIA						
Gallbladder disease								Thyroid						
GERD disease								Tuberculosis						
Glaucoma								Ulcer						

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

_____

_____

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 directly.
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 "as is 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.
310 S. GREENLEAF STREET, SUITE 209
GURNEE, IL 60031-5708

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 5/8/19

EYE CARE CENTER OF LAKE COUNTY
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 READ IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right to understand and control how your personal health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operation.

- Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this would include referring you to a retina specialist.

- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.

- Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, customer service, and compliance with the Affordable Care Act. An example of this would be new patient survey cards.

- The practice may also disclose your PHI for law enforcement and other legitimate reasons although we shall do our best to assure its continued confidentiality to the extent possible.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

We may contact you, by phone, in writing, secured email message, or text message to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, in addition to other fundraising communications, that may be of interest to you. You do have the right to "opt out" with respect to receiving fundraising communications from us.

The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:

- Most uses and disclosure of psychotherapy notes;
- Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations;
- Disclosures that constitute a sale of PHI under HIPAA; and
- Other uses and disclosures not described in this notice.

You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You may have the following rights with respect to your PHI.

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of Protected Health Information by alterative means or at alternative locations.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of your PHI.
- The right to obtain a paper copy of this notice from us upon request.
- The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for services "out of pocket", in full, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your Protected Health Information and to provide you the notice of our legal duties and our privacy practice with respect to PHI.

This notice if effective as of September 23, 2013 and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post and you may request a written copy of the revised Notice of Privacy Practice from our office.

You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with office and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Feel free to contact the Practice Compliance Officer for more information, in person or in writing.

NOTICE INFORMING INDIVIDUALS ABOUT NONDISCRIMINATION AND ACCESSIBILITY REQUIREMENTS

Eye Care Center of Lake County, Ltd. complies with all applicable Federal civil rights laws and does not discriminated on the basis of race, color, national origin, age, disability, or sex. Eye Care Center of Lake County, Ltd. does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Eye Care Center of Lake County, Ltd.:

1) Provides free aids and services to people with disabilities to communicate effectively with us, such as:
   - Qualified sign language interpreters
   - Written information in other formats (large print, audio, accessible electronic formats, other formats)
2) Provides free language services to people whose primary language is not English, such as:
   - Qualified interpreters
   - Information written in other languages
3) If you need these services, contact [Elizabeth LeClair, Practice Administrator-Civil Rights Coordinator]

If you believe that Eye Care Center of Lake County, Ltd. has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with [Elizabeth LeClair, Practice Administrator-Civil Rights Coordinator], 310 S. Greenleaf Street, Suite 209, Gurnee, IL 60031, telephone (847) 244-1657, fax (847) 244-5122, patient portal. You can file a grievance in person or by mail, fax, or patient portal. If you need help filing a grievance, [Elizabeth LeClair, Practice Administrator-Civil Rights Coordinator] is available to assist you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C., 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

LIMITED ENGLISH PROFICIENCY OF LANGUAGE ASSISTANCE SERVICES

1) **Español (Spanish)** ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-847-244-1657
2) **Polski (Polish)** UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-847-244-1657.
3) **繁體中文 (Chinese)** 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-847-244-1657
4) **한국어 (Korean)** 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-847-244-1657. 번으로 전화해 주십시오.
5) **Tagalog (Tagalog – Filipino)** PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-847-244-1657.
6) **(Arabic)** العربية
   حوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-847-244-1657 (رقم)
7) **Русский (Russian)** ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-847-244-1657.
8) **ગુજરાતી (Gujarati)** **સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો** 1-847-244-1657.
9) **اُردو (Urdu)** ردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں1-847-244-1657
10) **Tiếng Việt (Vietnamese)** CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1847-244-1657.
11) **Italiano (Italian)** ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-847-244-1657.
12) **हिंदी (Hindi)** ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-847-244-1657.
13) **Français (French)** ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-847-244-1657.
14) **λληνικά (Greek)** ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-847-244-1657
15) **Deutsch (German)** ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1847-244-1657.