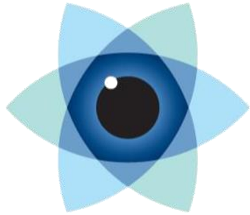


RETINA HEALTH INSTITUTE S.C.

Vision Redefined
2320 N Huntington Rd., Algonquin, IL, 60102
847-488-1030 (Office) 847-488-0677 (Fax)
www.retinahealthinstitute.com

LAST NAME:	FIRST NAME:	DOB:

REASON FOR VISIT: *(Please tell us a little regarding your visit today)*

Personal Medical History

Condition	Yes	No	Comments
CONSTITUTIONAL *e.g. fever, heat stroke, weight loss, weight gain, unusually tired, etc.*			
EAR/NOSE/THROAT *e.g. hard of hearing, stuffy nose, earache, cough, dry mouth, etc.*			
CARDIOVASCULAR *e.g. high blood pressure, racing pulse, chest pain,* *exercise intolerance, etc.*			
LUNG (RESPIRATORY) *e.g. congestion, wheezing, shortness of breath, cough - productive/blood, asthma, etc.*			
GASTROINTESTINAL *e.g. stomach upset, diarrhea, constipation, hernia, ulcers, pain/cramps, acid reflux, etc.*			
MUSCULOSKELETAL *e.g. muscle pain/cramps, joint pain swelling, stiffness, etc.*			
GENITOURINARY *e.g. painful urination, frequent urination, burning, impotence, incontinence, infections, etc.*			
GYNECOLOGICAL (FEMALE ONLY) *e.g. pregnancies, menstrual problems, ovarian & uterine conditions, etc.*			

BREAST (FEMALE ONLY)			
NEUROLOGICAL *e.g. numbness, weakness, headaches, paralysis, seizures, tremors, tingling, etc.*			
PSYCHIATRIC *e.g. depression, anxiety, mood swings, insomnia, hallucinations, disorientation, etc.*			
BLOOD/LYMPHATIC *e.g. cholesterolemia, anemia, blood disorders, leukemia, prolonged bleeding, etc.*			
SKIN *e.g. itching, rash, infection, ulcer, tumor/growths, warts, excessive dryness, etc.*			
CANCER			
ALLERGIC/IMMUNOLOGIC *e.g. recurrent infections, hay fever, food allergy,* *drug sensitivity, hives, redness, itching, etc.*			
ENDOCRINE *e.g. diabetes, thyroid problems, fatigue, hair loss, hot/cold intolerance, etc.*			

MAJOR ILLNESSES/HOSPITALIZATION ☐ Yes ☐ No	
SURGERIES ☐ Yes ☐ No	

If you are diabetic:

YEAR OF DIAGNOSIS:	**RESULT/TIME OF LAST BLOOD SUGAR:**
LAST HEMOGLOBIN A1C:	**DOCTOR & CONTACT INFORMATION:**
TREATMENTS:	

Family History *(Parents, Siblings, or Grandparents only)*

EYE DISEASE	
☐ Glaucoma ☐ Cataract ☐ Retinal Detachment ☐ Blindness	☐ Macular Degeneration ☐ Macular Dystrophy ☐ Retinitis Pigmentosa ☐ Retinal Degeneration
SYSTEMIC DISEASE	
☐ Diabetes ☐ Cancer ☐ Heart Disease	☐ Hypertension ☐ Arthritis ☐ Other:

Personal Social History

MARITAL STATUS:	**LIVING ARRANGEMENTS:**
TOBACCO USE: ☐ Never ☐ Current Everyday Use ☐ Current Some Day Use ☐ Former Use ☐ Status Unknown ☐ Other:______________________________.	
ALCOHOL USE: ☐ Never ☐ Current Everyday Use ☐ Current Some Day Use ☐ Former Use ☐ Status Unknown ☐ Other:______________________________.	
RECREATIONAL DRUG USE: ☐ Never ☐ Current Use ☐ Former Use ☐ Status Unknown ☐ Other:______________________________.	
OCCUPATION(S):	**OCCUPATIONAL EXPOSURE: ☐ Yes ☐ No**
RECENT TRAVEL: ☐ Yes ☐ No	
Have you been exposed to Venereal Disease/Sexually Transmitted Disease? ☐ Yes ☐ No	
Are you pregnant? (Female only) ☐ Yes ☐ No	

Personal Ocular History

DO YOU WEAR GLASSES/CONTACTS? **HOW LONG HAVE YOU USED THEM?**
DO YOU HAVE PROBLEMS WITH VISION?
HISTORY OF EYE TRAUMA?
DO YOU HAVE ANY EYE CONDITIONS? (CATARACT, GLAUCOMA, ETC.)
HAVE YOU HAD EYE SURGERY? **IF YES, WHEN?**

LAST EYE EXAM:
OTHER EYE CONDITIONS:

MEDICATIONS: *List ALL medications you are CURRENTLY taking. (include all herbals, vitamins & supplements)*

List drug, dose, how often taken and any other relevant details.

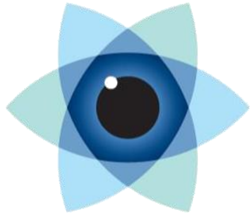
IF MEDICATION LIST IS TOO LONG THEN PLEASE ATTACH A SEPARATE SHEET

ALLERGIES: *List ALL allergies, severity, reaction and treatment information*

PREFERRED PHARMACY: *Please provide name and location of preferred pharmacy*

SIGNATURE **DATE**

PRINTED NAME



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PATIENT INFORMATION					
LAST NAME*	FIRST NAME*		MIDDLE INITIAL		
IF MINOR, NAME OF RESPONSIBLE PARENT					
DOB*	SOCIAL SECURITY #	DRIVERS LICENSE #*			
HOME ADDRESS*			APT/SUITE #		
CITY*	STATE*	ZIP*			
HOME #*	DAYTIME #	FAX #			
MOBILE #*	EMAIL ADDRESS*	☐ FEMALE* ☐ MALE*			
OCCUPATION	EMPLOYER	PHONE #			
ADDRESS	CITY	STATE	ZIP		

IF APPLICABLE, NAME OF SPOUSE/DOMESTIC PARTNER		
LAST NAME	FIRST NAME	MIDDLE INITIAL

IF PATIENT IS LIVING IN A NURSING FACILITY*		
NAME OF FACILITY*		
ADDRESS*	ROOM #*	
CITY*	STATE*	ZIP*

CONTACT INFORMATION FOR RESPONSIBLE PARTY/SPOUSE/PARENT (If info same as above, leave blank)		
LAST NAME	FIRST NAME	MIDDLE INITIAL
SOCIAL SECURITY #	RELATIONSHIP TO PATIENT	
ADDRESS	CITY	ZIP
HOME #	DAYTIME #	FAX#
CELL #	EMAIL ADDRESS*	

PATIENT REFERRAL INFORMATION			
PATIENT REFERRED BY*			PHONE #
ADDRESS	CITY	STATE	ZIP
PRIMARY CARE PHYSICIAN*			PHONE #
ADDRESS	CITY	STATE	ZIP

EMERGENCY CONTACTS (PLEASE FILL IN TWO WITH DIFFERENT CONTACT INFORMATION)				
NAME		RELATIONSHIP		PHONE #
ADDRESS	CITY		STATE	ZIP
NAME		RELATIONSHIP		PHONE #
ADDRESS	CITY		STATE	ZIP

EDUCATION, LANGUAGE & MISCELLANEOUS	
HIGHEST LEVEL OF EDUCATION	PREFERRED LANGUAGE
DO YOU NEED AN INTERPRETER?	
ETHNICITY:	RACE:

WHO CAN WE SHARE YOUR INFORMATION WITH?

Patient:____ **Date:**

Patient Representative / Parent: ______________________ **Date:**

For patients requiring translation or verbal reading of the document, the reader/translator may document and sign below.

Reader / Translator: **Date:**

Billing Information & Responsible Party / Insurance Information

LAST NAME:	FIRST NAME:	MIDDLE INITIAL:

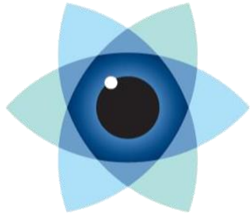
INSURANCE INFORATION		
PRIMARY INSURER*	NAME OF INSURED*	FROM
INSURANCE ID# / GROUP # / OTHER INFORMATION		
SECONDARY INSURER*	NAME OF INSURED*	FROM
INSURANCE ID# / GROUP # / OTHER INFORMATION		
TERTIARY INSURER*	NAME OF INSURED*	FROM
INSURANCE ID# / GROUP # / OTHER INFORMATION		
PHARMACY INSURER*	NAME OF INSURED*	FROM
INSURANCE ID# / BIN # / PCN # / GROUP # / OTHER INFORMATION		

Patient: ____ **Date:** _________________

FOR OFFICE USE ONLY:

Physician To Be Seen:__________________________________ **Date:**_________________

Account Number Assigned: ____________________________ **Initials:** _______________



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BENEFITS ASSIGNMENT

Last Name	First Name	DOB
Address		SSN

AUTHORIZATION FOR MEDICAL INFORMATION RELEASE - I authorize Retina Health Institute, S.C. to release to my insurance company, any medical information needed to determine benefits payable for related services.

AGREEMENT OF RESPONSIBILITY – I understand that professional services are rendered and charged to the patient. CO-PAY IS DUE AT THE TIME OF SERVICE (Co-insurance and deductibles may also be collected at the time of service). I understand I am financially responsible for charges not covered by my insurance company. I also agree to pay any outstanding balance, as well as attorney fees and costs to Retina Health Institute, S.C. if this matter is referred to collection.

RELEASE OF INFORMATION/ASSIGNMENT OF BENEFITS – I authorize use of this form for release of information needed to process claims to all my insurance companies. I permit a copy of this authorization to be used in place of the original. I authorize the provider to act as my agent in helping obtain payment from my insurance companies. I assign all rights and claims for reimbursement of expenses allowable under my insurance plan and authorize payment directly to the provider for services rendered. I understand I will receive monthly statements for any balance due by me. I also understand, full payment is required to be made on receipt of your 1st statement after insurance has met their obligation.

MEDICARE AUTHORIZATION – I request payment of authorized Medicare benefits be made on my behalf to Retina Health Institute, S.C., for any services provided to me by that physician/supplier. I authorize the holder of medical information about me to release to Medicare and its agents, any information needed to determine these benefits or benefits payable for related services.

I understand my signature requests payment to be made and authorize release of medical information necessary to pay claims. If 'other health insurance' is indicated in item 9 of the HCFA-1500 Form, or elsewhere on approved claim forms, or electronically submitted claims, my signature authorizes release of information to insurer or agency shown. In Medicare assigned cases, the physician/supplier agrees to accept the charge of determination of the Medicare carrier as the full charge – the patient is responsible for deductible, co-insurance and non-covered services. Co-insurance and deductibles are based upon the charge determination of the Medicare carrier.

MEDIGAP/SUPPLEMENTAL AUTHORIZATION - I request payment of authorized Medigap/Supplemental benefits on my behalf to Retina Health Institute, S.C., for any services furnished me by that physician/supplier. I authorize holder of my medical information to release to Medigap/Supplemental and its agents, any information needed to determine these benefits or the benefits payable to related services.

AUTHORIZATION – INSURANCE/FINANCIAL MATTERS - By my signature, I also authorize Retina Health Institute, S.C., to discuss financial/insurance matters on my behalf with those persons designated below (Please PRINT complete names & relationship):

PATIENT:	DATE:

Attestation

I, ____, hereby give my consent to Retina Health Institute, S.C., to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in my patient record.

I acknowledge having received a copy of the Notice of Privacy Practices which contains a more complete description of the uses and disclosures of my health information. I understand that the practice has the right to change its Notice of Privacy Practices from time to time and that I may contact the practice at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to Retina Health Institute. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my Protected Health Information.

I understand that, under the HEALTH Insurance Portability & Accountability Act of 1966 (HIPAA), I have certain rights to privacy regarding my protected health Information. I understand this Information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

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 DATE

____

PATIENT REPRESENTATIVE / PARENT DATE

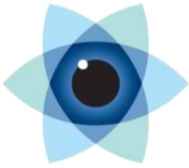
FOR OFFICE USE ONLY:

I attempted to obtain patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so:

Reason:

____

PRACTICE REPRESENTATIVE DATE



RETINA HEALTH INSTITUTE S.C.

Vision Redefined

PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing Retina Health Institute ("RHI") as your healthcare provider. We are honored by your choice and are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

- The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for his/her treatment and care.
- We are pleased to assist you by billing for our contracted insurers. However, the patient is required to provide us with the most correct and updated information about their insurance and will be responsible for any charges incurred if the information provided is not correct or updated.
- Patients are responsible for the payment of copays, coinsurance, deductibles, and all other procedures or treatment not covered by their insurance plan. Payment is due at the time of service, and for your convenience, we accept cash, check, and most major credit cards at our office.
- Patients may incur and are responsible for the payment of additional charges at the discretion of RHI. These charges may include (but are not limited to):
  - Charge for returned checks.
  - Charge for missed appointments without 24 hours advance notice
  - Charge for extensive phone consultations and/or after-hours phone calls requiring diagnosis, treatment, or prescriptions.
  - Charge for the copying and distribution of patient medical records.
  - Charge for extensive forms completion.
  - Any costs associated with collection of patient balances.

Patient Authorizations

- By my signature below, I hereby authorize RHI and the physicians, staff, and hospitals associated with RHI to release medical and other information acquired in the course of my examination and/or treatment to the necessary insurance companies, third party payors, and/or other physicians or healthcare entities required to participate in my care.
- By my signature below, I hereby authorize assignment of financial benefits directly to RHI and any associated healthcare entities for services rendered as allowable under standard third-party contracts. I understand that I am financially responsible for charges not covered by this assignment.
- By my signature below, I authorize RHI personnel to communication by mail, answering machine message, and/or email according to the information I have provided in my patient registration information.
- By my signature below, I authorize RHI to securely store my credit card information and only charge it should I have an outstanding balance or any leftover balance from a processed claim in the future. I am aware that the storage system used is fully compliant to the highest level of credit card storage security regulations. Once stored, I am aware that only the last 5 digits of my card are viewable by RHI personnel. I understand that I am responsible for all charges for services that I receive from RHI, and that if the patient responsibility portion of my charges (including charges applied to my deductible and/or coinsurance) is not paid in full within thirty (30) days following the receipt of the patient financial responsibility statement mailed from the RHI Billing Office, RHI will bill my stored credit card for the outstanding balance due.

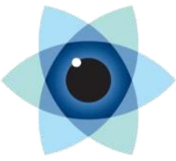
I have read, understand, and agree to the provisions of this Patient Financial Responsibility Form:

Signature of Patient or Guardian Date

Waiver of Patient Authorizations

I do not wish to have information released and prefer to pay at the time of service and/or to be fully responsible for payment of charges and to submit claims to insurance at my discretion.

Signature of Patient or Guardian Date



RETINA HEALTH INSTITUTE

RASHMI KAPUR MD
REHAN HUSSAIN MD

Medical Release of Information

Patient Name: ____ DOB: ________________________

I hereby give my consent and authorize to the following facility:

Retina Health Institute, SC
2320 N Huntington Rd
Algonquin, IL 60102
Tel: 847.488.1030 Fax: 847.488.0677

To have access to my;

Medical Records, Physician Notes, Laboratory Reports, Pathology Reports, Radiology Reports, Procedural/Operative Reports and Consultation Reports.

I understand that I may revoke this consent in writing at time, although not retroactively, and that upon fulfillment of the above request medical information or the lapse of one (1) year from the date of signature, whichever comes first, this consent will automatically expire without my expressed revocation. A photocopy of this authorization shall be as valid as the original.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or copy the information to be used or disclosed as provided in 45 C F R 165.524. I understand any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. The patient's medical record is privileged information, which is protected by various State and Federal Laws. Such information may not be further disclosed to other persons or entities without a separate written authorization from the patients.

I understand that the information in my health record may include information relating to sexually transmitted diseases, such as the Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV). It may include information about behavioral or mental health services, and treatment of alcohol and drug abuse.

Patient must sign unless he/she is a minor under 18 or is unable to sign. If signature is not of a patient, indicate the relationship to patient.

Patient Signature: _______________________________________ Date: ________________________

Relationship to Patient: ____

Specialists in Adult Retina Care

- Macular Degeneration
- Diabetic Retinopathy
- Retinal Detachment
- Ocular Oncology
- Uveitis

Algonquin Office

2320 N Huntington Dr
Algonquin, IL,
60102
847-488-1030 (Office)
847-488-0677 (Fax)

Rockford Office

1075 Featherstone Rd,
Suite 10
Rockford, IL, 61107
815-904-6016 (Office)
815-904-6256 (Fax)

www.retinahealthinstitute.com

NON-COVERED SERVICE FEES

Effective 1/1/2023

- Explanation of Bill → **$30.00**
- Tinted Glasses → **$1**
- Masks → **$1**
- Yearly Prior Authorizations → **$100**
- Prescription refill request outside of appointment time → **$25**
- No show/cancellation fee if not done 24/hrs in advance → **$75-$150***
    - **This does not apply to emergencies.*
- Coordination of benefits →**$100 for the year**
- Not scheduling appointment on exit (Starts 4/1/2023) → **$15**
- Appeals after first attempt → **$50**
- Non urgent page to doctors after hours → **$20**
- Requested no balance/credit statement → **$10**
- Incorrect insurance on file → **$300**

*****Patients who frequently reschedule their appointments are subject to an additional rescheduling fee****

I have read, understand, and agree to the provisions of the Non-Covered Service Fees:

Patient Name: ____

Signature of Patient or Representative: ____ Date: _________