Retina Institute of Illinois, P.C.

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Susan Vierling, MD Anna Sporysheva, MD

Today's Date: _____

Name: _____ *Date of Birth: _____
Address: _____

City: _____ State: _____ Zip: _____

Sex (Circle): Male Female *Social Security No. _____

***Home Phone: _____ Cell Phone: _____**
Work Phone: _____
***Email Address: _____**

Spouse's Name: _____ Phone: _____

***Emergency Contact Person: _____ Phone: _____**
Relationship to Patient: _____

Eye Doctor Name and Contact Info: _____
_____

Primary Doctor's Name and Contact Info: _____
_____

***

Race: _____ (ex: Caucasian, Hispanic, Asian, African American, etc)
Ethnicity: _____ (ex: German, Spanish, Korean, Chinese, etc)
Language/Spoken: _____

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<u>INSURANCE INFORMATION:</u>
***Primary Insurance: _____**
Insured's Name if different from Patient: _____
Date of Birth: _____ SSN: _____
Relationship to Patient: _____
****Secondary Insurance: _____**

Retina Institute of Illinois will bill any insurance company it provides services. This will be done one time as a courtesy to our patients. The patient is responsible for copays and deductibles, and amounts the insurance does not cover. Any dispute is the patient's responsibility.

_____ _____
Patient Signature **Date**

Retina Institute of Illinois, P.C.

I understand that services rendered to me by Retina Institute of Illinois are my financial responsibility and that the Provider will bill my insurance company as a courtesy. I authorize my insurance company to pay my benefits directly to **Retina Institute of Illinois and I understand that I will be fully responsible for any outstanding balances on my account.**

I have been given the opportunity to pay my estimated deductible and co-insurance at the time of service. I have chosen to assign the benefits, knowing that the claim must be paid within all state of federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the prompt payment of the claim

I authorize the provider to release any information necessary to adjudicate the claim and understand the there may be associated costs for providing information above any beyond what is necessary for the adjudication of a clean claim. I also understand that should my insurance company send payment to me, I will forward the payment to Retina Institute of Illinois within 48 hours. I agree that if I fail to send the payment to the Provider and they are forced to proceed with the collections process. I will be responsible for any cost incurred by the office to retrieve their monies.

To avoid this additional cost and inconvenience, should the insurance company forward payment to me, **I authorize Retina Institute of Illinois to facilitate payment utilizing the credit card number on file to resolve the balance. (ONLY if credit card number has been provided).**

I authorize the provider to initiate a complaint to the insurance commissioner for any reason on my behalf and I personally will be active in the resolution of the claims delay or unjustified reductions or denials.

Receipt of Notice of Privacy Practices Form:

I hereby acknowledge receipt of Retina Institute of Illinois Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how Retina Institute of Illinois may use and disclose my confidential information. I understand that Retina Institute of Illinois reserves the right to change their privacy practices. By signing below I acknowledge that I am the patient or guardian of the patient & that I have received for my review, the attached notice of privacy practices for all offices of:

X_____ _____

Patient Name Date of Birth

X_____

Signature of Patient/Legal Guardian

RETINA INSTITUTE OF ILLINOIS
Mandatory Credit Card Policy 2025

The Retina Institute of Illinois is implementing a new policy in 2025.

For all patients that always pay their responsible balances in a timely manner, we greatly appreciate your conscientiousness and apologize for any inconvenience this may cause. It has become mandatory for our practice to require a credit card to be kept on file for any balances that may accrue on your patient account.

This policy applies to all patients, excluding those covered by a **Medicare Standard Policy.**

You will receive **3 paper statements by mail** at 30 days, 60 days and the final statement at 90 days after your visit. If the balance reaches an aged date exceeding 90 days with no payment, the credit card on file will be charged for the balance and you will receive a mailed receipt for your records.

By signing below, you authorize The Retina of Illinois to charge the credit card on file for any outstanding patient balance exceeding an aged date of 90 days or more.

Patient Signature _____ Date _____

Name on Card _____
Credit Card Number: _____
Expiration Date _____ CVV _____
Mailing address _____
_____
Contact Phone Number _____

Retina Institute of Illinois 2025 Policies

Insurance Processing Policy

_____Patient Initials – I certify that the insurance coverage I provided to the office is valid and I assign directly to this medical practice all insurance benefits. I understand that I am financially responsible for all charges whether paid by insurance or not. I authorize the use of my signature on all insurance submissions.

24 Hour Appointment Cancellation Policy

_____Patient Initials – I acknowledge the 24-hour cancellation policy for this practice that states if I miss or cancel my appointment with less than 24 hours notice that I will be charged $50.00

Credit Card Policy

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Patient Signature: _____ Date _____