



Macon County Eye Center
 646 W Pershing Road
 Decatur, IL 62526
 (217) 875-0300

PATIENT INFORMATION

NAME (Last, First Middle)				MRN	SSN#	BIRTHDATE	SEX
LOCAL ADDRESS				CITY, STATE ZIP		SECONDARY/BILLING ADDRESS (if Applicable)	
HOME PHONE	DAY PHONE	EMAIL ADDRESS		REFERRING PHYSICIAN		CITY, STATE ZIP	
MARITAL STATUS	STUDENT STATUS <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	SMOKER (Y/N)?	VETERAN (Y/N)?	PRIMARY CARE PROVIDER		HOME PHONE	
PRIMARY EMPLOYER				SECONDARY EMPLOYER (if Applicable)			
ADDRESS				ADDRESS			
CITY, STATE ZIP				CITY, STATE ZIP			
WORK PHONE				WORK PHONE			

RESPONSIBLE PARTY INFORMATION (if Different than above)

NAME (Last, First Middle)				SSN#	BIRTHDATE	SEX	
LOCAL ADDRESS				CITY, STATE ZIP		SECONDARY/BILLING ADDRESS (if Applicable)	
HOME PHONE	DAY PHONE	EMAIL ADDRESS		CITY, STATE ZIP			
MARITAL STATUS	STUDENT STATUS <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	SMOKER (Y/N)?	VETERAN (Y/N)?	PRIMARY CARE PROVIDER		HOME PHONE	
RELATIONSHIP TO PATIENT							

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY				POLICY#			
NAME OF INSURED				GROUP#			
ADDRESS OF INSURANCE COMPANY				COPAY AMT \$			
CITY, STATE ZIP		PHONE		DEDUCTIBLE \$			
RELATIONSHIP TO PATIENT				EFFECTIVE DATE		EXPIRATION DATE	

SECONDARY INSURANCE (if Applicable)

NAME OF INSURANCE COMPANY				POLICY#			
NAME OF INSURED				GROUP#			
ADDRESS OF INSURANCE COMPANY				COPAY AMT \$			
CITY, STATE ZIP		PHONE		DEDUCTIBLE \$			
RELATIONSHIP TO PATIENT				EFFECTIVE DATE		EXPIRATION DATE	

Is this a work related injury? YES NO If yes, Supervisor's Name: _____ Supervisor Phone: _____

Emergency Contact Name: _____ Relationship to Patient: _____ Phone #: _____

How did you hear about our practice? (Circle One)

Employee Referral Health Fair/Seminars Lasik Patient Newspaper Ad Insurance Company Radio Ads Friend/Neighbor Yellow Pages

Patient Referral - Enter - Patient Name _____

Insured's Date of Birth _____ Insured's Social Security Number _____

SIGNATURE OF PATIENT/GUARDIAN

DATE



Ophthalmologists: Dr. Sushant Sinha • Dr. Christine Warchol

Optometrists: Dr. David Morgret

TO BILL YOUR INSURANCE WE NEED COPIES OF YOUR INSURANCE CARDS

This signed authorization permits any physician and /-or person practicing at Macon County Eye Center P.C. to treat me as a patient. I authorize the release of any information necessary for the processing of insurance and authorize assignment of payment of benefits for services provided to me are made directly to Macon County Eye Center.

I agree that in the event any unpaid balance, including principal, interest and late fees, is placed with or referred to a collection agency, attorney or other third part collection service for collection, a fee of 30.0% of the unpaid balance shall be added to the unpaid balance due from me. In addition, I agree to pay all other costs incident to collection incurred directly or indirectly by Creditor or by the collection agency, attorney or other third party collection service, to collect the total amount due from me under this agreement.

I understand it is my responsibility to provide adequate insurance information if I want all services to be billed directly to my insurance company or I will be responsible for the fees in full to be paid for at the time of service. If my insurance requires prior authorization and / or referral forms, this is my responsibility.

X _____ Date: _____
(Signature of Patient / Guardian of Minor)

Please provide Social Security Number of Person Signing Consent for a Minor for Billing Purposes: ____/____/____

Authorization to Bill Medicare:

X _____
Name / Signature of Patient

Date: _____

I request the payment of authorized Medicare Benefits be made either to me or on my behalf to Macon County Eye Center P.C. for any services furnished me by their physicians. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits for related services.

Authorization to Bill Medicare Supplement:

X _____
Name / Signature of Patient

Date: _____

I request that payment of authorized Medicare Supplemental Insurance (Medigap) benefits be made on my behalf to Macon County Eye Center P.C. for any services furnished me by their physicians. I authorize any holder of medical information about me to release to _____ (name of insurance) any information needed to determine these benefits payable for related services.



Ophthalmologists: Dr. Sushant Sinha * Dr. Christine Warchol

Optometrists: Dr. David Morgret

Consent for Release and Use of Confidential Information and Receipt of Notice of Privacy Practices Form

I, _____, hereby give my consent to Macon County Eye Center
(Name of Patient or Authorized Agent)

to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in the patient record of _____.
(Patient's Name)

I acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available in paper format upon request or upon my next visit to the clinic following the revision.

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 the physician. 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 health information. Written revocation of consent must be sent to the physician's office.

Signed: _____ Date: _____

If you are not the patient, please specify your relationship to the patient _____.

– Patient's file

646 W. Pershing Road * Decatur, Illinois 62526
217-875-0300 * Fax 217-875-9525
1-800-500-7204

www.maconeye.com

CONSENT FORM DEFINITIONS *(Backside of Consent for Release and Use of Confidential Information and Receipt of Notice of Privacy Practices Form)*

“Health care operations” refers to a large number of activities, including:

1. Conducting quality assessment and improvement activities, including outcome evaluation and development of clinical guidelines, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from such activities; population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting of health care providers and patients with information about treatment alternatives; and related functions that do not include treatment;
2. Reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, health plan performance, conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers, training of non-health care professionals, accreditation, certification, licensing, or credentialing activities;
3. Underwriting, premium rating, and other activities relating to creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance);
4. Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;
5. Business planning and development, such as conducting cost management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies; and
6. Business management and general administrative activities including but not limited to: (a) management activities relating to HIPAA privacy rule compliance; (b) customer services, including the provision of data analyses for policy holders, plan sponsors, or other customers, provided that protected health information is not disclosed to such policy holder, plan sponsor, or customer; (c) resolution of internal grievances; (d) due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a covered entity or, following completion of the sale or transfer, will become a covered entity; and (e) creating de-identified health information, fundraising for the benefit of the covered entity, and marketing for which an individual authorization is not required.

“Payment” means the activities undertaken by the physician to obtain reimbursement for the provision of health care. These activities referred to in this definition relate to the individual to whom health care is provided and include, but are not limited to:

1. Determination of eligibility coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication or subrogation of health benefit claims;
2. Billing, claims management, collection activities, obtaining payment under a contract for reinsurance, and related health care data processing;
3. Review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges;
4. Utilization review activities, including precertification and preauthorization of services, concurrent and retrospective review of services; and
5. Disclosure to consumer reporting agencies of any of the following information relating to reimbursement: name and address, date of birth, Social Security number, payment history, account number, and name and address of the physician.

“Treatment” means the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider or another.

“Use” means the sharing, employment, application, utilization, examination, or analysis of patient information within the physician’s practice that maintains such information.