Grassi Retina
1012 W. 95th Street, Suite 9
Naperville, IL 60564
PH (630) 995-3465
FAX (630) 995-3622
www.grassiretina.com

_____

Patient Number

WELCOME TO GRASSI RETINA!

These are your new patient forms.

Please fill out *ONLY* the highlighted portions on the forms attached and return them to the front desk when finished.

1) The first form is a **Request for Medical Records**. By filling out this form, you give our office permission to contact any of your physicians listed in our records regarding your medical care, should we need to do so.
2) The second form is a **Notice of Personal Healthcare Representative Designation Form**. Any person you list on this form will have permission to contact us about your Protected Health Information, including making appointments for you and/or paying your bill. If their name is not on this form, we will not be able to speak with them or even confirm that you are a patient here.
3) The third form details our **Patient Financial Policy**. You are welcome to keep this form for your records but you must return the signature page to us. By signing this form, you agree to abide by your contract with your insurance company and pay your copay at the time of service as well as your deductible or coinsurance within 30 days. You also agree to keep a card on file in the event that your balance is not paid within 60 days (past due from the time that the balance is assigned to you). We do offer generous payment plans which can help you with larger balances but you must call us and set up an approved plan (usually 3 months to pay, without interest). You are also agreeing to our missed appointment and “no show” policy. *It is very important that you read and understand this form. Please ask questions if you do not*.

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Request for Medical Records

Today's Date: _____

Patient Information:
I understand this Authorization is subject to revocation by me at any time in writing except to the extent that the action has already been taken to release this information. This authorization shall remain valid for 60 days after the date above unless revoked prior to that time.

Patient Name: _____

Date of Birth: _____/_____/_____

Patient Signature: _____

TO:
Doctor / Group Name:

_____FAX:_____

Requesting Office Information

GRASSI RETINA
Michael A. Grassi, MD
1012 95th Street, Suite 9
Naperville, IL 60564
630/995.3465 Office / 630.995.3622 FAX

Purpose of Request:

☒ Continuity of Care / Coordination

Grassi Retina is requesting the following information:

☒ Notes from patients **LAST** visit including any Labs/Test results.

☐ _____

Thank you for your assistance!

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Notice of Personal Healthcare Representative Designation Form

Federal law says that Grassi Retina MD SC cannot share your Protected Health Information without your permission. If you sign this form, you are giving Grassi Retina MD SC permission to share your Protected Health Information with those person(s) you name as your Personal Healthcare Representative.

- You can name more than one person as your Personal Healthcare Representative.
- The Personal Healthcare Representative designation will last until you tell Grassi Retina MD SC that you do not want the person(s) named below as your Personal Healthcare Representative any longer.
- Right to Revoke: If you decide you do not want us to treat any of the person(s) below as your Personal Healthcare Representative, please inform us and we will give you a new form. The Practice cannot cancel disclosures that were already made to a Personal Healthcare Representative.
- You can keep a copy of this Personal Healthcare Representative form and can contact Grassi Retina MD SC to get an additional copy.
- This form allows Grassi Retina MD SC staff to **speak verbally** to the following individuals about my medical care, without informing me, including clinical information, billing information, insurance information, appointment dates and times, and any other information they seek.
- This form allows Grassi Retina MD SC staff to **share written/printed medical records and/or give access to the patient portal** to the following individuals about my medical care, including clinical information, billing information, insurance information, appointment dates and times, and any other information they seek.

I _____ hereby give my consent to Grassi Retina MD SC to treat the following person(s) as my Personal Healthcare Representative(s):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I understand that this 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 Grassi Retina MD SC. 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. Written revocation of consent must be sent to Grassi Retina MD SC 1012 95th street Naperville, IL 60564.

Patient Signature: _____ Date: _____

NOTE: If patient is not able to sign, please provide name and relationship of anyone to helping to fill out this form

Name: _____ Relationship: _____

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Grassi Retina MD SC Patient Financial Policy 2024

Thank you for choosing Grassi Retina MD SC for Expert Medical Retina Care. We are committed to providing the highest quality retina care available anywhere. In order to accomplish this goal, we have put in place a Financial Policy that allows us to care for you while meeting our financial obligations.

Please read this policy and ask us any questions you may have and then sign in the space provided. A copy will be provided to you upon request.

- **Insurance**. We are contracted with most insurance plans. If we are contracted with your insurance, we will submit claims for you as a courtesy and wait to accept their payment. You will only be responsible after we determine what your insurance assigns to you as coinsurance/deductible/patient responsibility. If we are not contracted with your insurance, we will do our best to communicate this to you before your visit and payment in full will be expected at each visit. If you are seeing us out of network or your insurance is inactive, payment in full for each visit is required. Knowing your insurance benefits is your responsibility. Please contact your insurance company prior to your appointments with any questions you may have regarding your coverage. Please be sure to specify that you are seeing *"Dr. Michael Grassi in his Naperville office"* to ensure that you have coverage at this location.
- **Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients is a violation of our contract with your insurance company. Please help us in honoring your contract with your insurance by paying your co-payment at each visit.

- **PLEASE INITIAL**
  - **Credit Card on File:**
    This does not apply ONLY IF you have regular Medicare Part B (not Part C, not Disability) ***with a secondary that has no deductible/coinsurance/copay***
    - **Grassi Retina requires that you keep a credit card on file with our office to pay any balance due after insurance has paid its portion of your bill. We will send you an invoice and wait 30 days for payment. If payment is not received after 60 days, we reserve the right to charge**

your credit card for the balance due. Please initial here to indicate that you have read and understand this _____

- **Nonpayment**. If your credit card on file is declined and your account is over 60 days past due, you will be dismissed from our practice and your account will go into Collections.
- **Proof of insurance**. All patients must complete the patient registration process prior to their appointment. If you fail to provide us with the correct insurance information, your appointment will be canceled and rescheduled for when your insurance information has been entered and verified. Patients must understand their own insurance policies including deductibles and coinsurances and copayments. While we are happy to assist you, we cannot quote you your insurance benefits. If you have any questions about your coverage, you should call your insurance company.
- **Claims submission**. We will submit your claims to your insurance company for you as a courtesy and assist you in any way we reasonably can to have your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that you will be responsible for the balance of your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
- **Insurance coverage changes and Coordination of Benefits**. If your insurance changes or asks you to coordinate your benefits, please notify us as soon as possible before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days due to "inactive" coverage or lack of coordination of benefits or you did not pay your premiums to keep your insurance active, the balance will automatically be billed to you.

- **PLEASE INITIAL:**
  - **No Show/Same Day Canceled/Missed appointments. Our policy is to charge $50 for missed appointments that are not canceled within 48 hours of your appointment time. This is because our staff has already been scheduled and all materials have been prepared for your specific appointment. Less than 48 hours notice does not allow us enough time to schedule another patient into your reserved spot. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your scheduled appointment. Of course, last minute issues arise that cannot be avoided. The $50 no show fee will be considered on a case by**

case basis. Please initial here to indicate that you have read and understand our no show policy _____

- **Billing Questions:** If you have any questions about your medical bill, please first review your Explanation of Benefits (EOB) that your insurance company has mailed you or is available on your insurance website and then contact us at 630.995.3465 and ask for the Billing Manager. We are happy to review your statement with you and make sure that it is accurate. Please be advised that medical bills that were billed correctly and have accurate "patient responsibility" balances as determined by your insurance company are not negotiable at our office.

Our practice is committed to providing the best treatment to our patients. Having a payment policy in place helps us to run our practice at peak efficiency while delivering expert care to our patients.

Thank you for understanding our Patient Financial Policy. Please let us know if you have any questions or concerns. Please return this signed payment policy to the office at your earliest convenience.

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Insurance Information Release Authorization: I acknowledge that I have reviewed, understood and agree to the financial policy of Grassi Retina MD SC as stated in this document.

I hereby authorize Grassi Retina to release the medical information to my insurance company to process claims.

Patient (or Authorized Representative/Responsible Party)

Print your name:_____

*Signature:*_____

*Date:*_____