KESSLER OPTICAL

44 E. Main St. Champaign, IL 61820 • 217-356-5377
www.kessleroptical.com

Thank you for scheduling your appointment(s) with Dr. Kessler. Below are the bullet points/items discussed during our telephone conversation:

- **Location:** 44 E Main St Downtown Champaign, across from Joseph Kuhn's men's clothiers, Jupiter's Bar and Grill and the Gold Rush pawnshop.
- **Parking:** There are assigned spaces in the parking lot located next to the Gold Rush pawnshop OR if you park at a meter we can validate your parking with our meter key. Simply let us know you are parked at a meter. However, it is your responsibility to keep track of time. If you see that you are running out of time on your meter, let us know and we will give you the key again. Do not park in the parking lot next to Kessler Optical. That is not our parking lot. Your car will be towed from this lot. Kessler Optical is not responsible for towed vehicles.
- **Medical and Vision Benefits:** It is ultimately your responsibility to be familiar with your vision benefits coverage. We will TRY to review your benefits before your appointment as long as you have provided the correct information to our office. If we need more information, someone from our office will contact you.
- **Payment Options:** Kessler Optical takes cash, check, every major credit card, as well as FSA and HSA cards. Additionally, patients can apply in the office for financing through CareCredit with a 6-month no-interest plan.
- **Paperwork and Insurance:** If you are a new patient or this is your first time to Dr. Kessler's new office, you will receive any required paperwork via email. Please read and complete all forms, sign all places which require signatures and bring it with you. Dr. Kessler requires that patients arrive 15 minutes prior to their scheduled appointment time so that we can review your paper work and copy your insurance cards. Please remember to bring your HEALTH INSURANCE card, e.g., Health Alliance, BCBS etc.
- **Cancellation/No Show Policy:** We will call to confirm your appointment within 48 hours of your reserved appointment time. If you need to cancel an appointment, Dr. Kessler requires at least 24-hours notice. There is a $40 fee for appointments canceled with less than 24 hours notice and for no show appointments.
- **Timeliness:** In the event you are running late please call our office 217-356-5377 to let us know. If you are late for your appointment, we may need to reschedule.
- Dr. Kessler works very hard to keep to his schedule. Occasionally there may be a wait due to emergencies or complex cases. If a specific departure time is required, please let our front desk manager know upon your arrival. We will do our best to accommodate your needs!

Kessler Optical

General Information

Date: ____ / _____ / _____

Last Name: ______________________________ First Name: ________________ M: _______ DOB: _____ / ___ / ____

M or F SSN: _________ / ______ / ________ Marital Status: Married / Single / Divorced / Widowed

Address: ______________________________________ City: ______________________ State: ____ Zip: ___________

Home Ph: ( ) ___________________ Work Ph: ( ) ___________________ Cell Ph: ( ) ______________________

Employer/School:_______________________________ Occupation/School Grade: _____________________________

E-mail Address: _____________________________________ Sports/Hobbies: _________________________________

Emergency Contact: _______________________________ Relation: _________________ Phone #: ( ) _______________

Do you have vision insurance? Yes ____ No ____ Do you have health insurance? Yes ____ No ____

Do you have Medicare? Yes ____ No ____ Referred by: ____

CASE HISTORY / REASON FOR VISIT:

Date of Last Medical Exam: ____ / ___ / ____ Primary Physician/Clinic: ___________________________________

Date of Last Eye Exam: ____ / ___ / ____ Clinic/Eye Doctor's Name: ___________________________________

Do you wear glasses? Yes / No / All the time / Sometimes / Work only / Reading only / Driving only

How old are your present glasses? ________________________________ Do you wear prescription Sun Wear? Yes / No

Do you wear contacts? Yes / No Type: ___________________________ Solution Used: ___________________________

Wearing schedule: Daily Overnight Replacement schedule: Daily 2-Week Monthly Yearly

Have you ever had eye injuries? Yes / No Which eye? ____

Have you ever had eye surgeries? Yes / No Why? ____

Have you ever used eye medication? Yes / No Why? ____

Are you currently pregnant or nursing? Yes No N/A

Have you ever been diagnosed with?

Cataracts: Yes / No When were you diagnosed? ____

Glaucoma: Yes / No When were you diagnosed? ____

Macular Degeneration: Yes / No When were you diagnosed? ____

What are your visual symptoms? Please circle any that apply:

[ ] Blurred Vision/Distance	R L B	[ ] Dry Eyes	R L B	[ ] Headaches	R L B
[ ] Blurred Vision/Near	R L B	[ ] Red Eyes	R L B	[ ] Migraine Headaches	R L B
[ ] Double Vision	R L B	[ ] Watery Eyes	R L B	[ ] Loss of Vision	R L B
[ ] Eye Strain	R L B	[ ] Wandering eye	R L B	[ ] Crossed Eyes	R L B
[ ] Eye Infections	R L B	[ ] Mucus Discharge	R L B	[ ] Light Sensitive	R L B
[ ] Eye Pain/Soreness	R L B	[ ] Floaters or Spots	R L B	[ ] Sandy/Gritty Feeling	R L B
[ ] Tired eyes	R L B	[ ] See Flashes	R L B	[ ] Poor Color Vision	R L B
[ ] Burning Eyes	R L B	[ ] See Halos	R L B	[ ] Droopy Lid	R L B
[ ] Itchy Eyes	R L B	[ ] Poor Night Vision	R L B		

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Please turn over and complete other side

PERSONAL MEDICAL HISTORY (REVIEW OF SYSTEMS) : PLEASE CHECK IF ANY OF THE FOLLOWING **APPLIES** TO YOU, AND LIST ANY MEDICATIONS FOR EACH CONDITION THAT YOU CHECK. IF YOU HAVE NONE OF THESE CONDITIONS, **PLEASE CHECK NONE.**

Constitutional: __ **None**	**Ear/Nose/Throat:** __ **None**	**Neurological:** __ **None**
___ Fatigue Syndrome ___ Cancer ___ Developmental Disability ___ Other:	___ Dry Mouth ___ Laryngitis ___ Hearling Loss ___ Upper respiratory/Sinus	___ Epilepsy ___ Multiple Sclerosis ___ Migraine ___ Celebral Palsy ___ Stroke/CVA
Psychiatric: __ **None** ___ Anxiety ___ Depression ___ Bipolar ___ ADHD ___ Autism Spectrum Disorder	**Cardiovascular:** __ **None** ___ Stroke/CVA ___ Vascular Disease ___ Heart Disease ___ Hypertension ___ Congestive Heart Failure	**Respiratory:** __ **None** ___ Emphysema ___ Bronchitis ___ Sleep Apnea ___ COPD ___ Other: ___ Asthma
Gastrointestinal __ **None** ___ Ulcer ___ Celiac ___ Crohn's ___ Colitis ___ Other:	**GU:** __ **None** ___ Prostate ___ Herpes ___ Kidney Disease ___ STD ___ Chlamydia	**Musculoskeletal:** __ **None** ___ Ankylosing Sodylitis ___ Fibromyalgia ___ Arthritis/Gout ___ Muscular Dystrophy ___ Other:
Integ/Dermatologic: __ **None** ___ Herpes Zoster,Shingles ___ Psoriasis ___ Herpes Simple/Cold sores ___ Eczema ___ Rosacea	**Endocrine:** __ **None** ___ Thyroid ___ Type 2 Diabetes (non insulin dependent) ___ Type 1 Diabetes (insulin dependent)	**Hema/Lyphatic** __ **None** ___ Ulcer ___ High cholesterol ___ Anemia
Allergy/Immunologic __**None** ___ Lupus ___ Environmental Allergies ___ Sjogrens Syndrome ___ Rheumatoid Arthritis ___ Drug Allergies	**Alcohol Use: Y N** **Tobacco Use: Y N**	

Please list any medications and/or drugs that you are taking (including herbal) : See Attatched List: __________

1	**For**		**6**	**For**	
2	**For**		**7**	**For**	
3	**For**		**8**	**For**	
4	**For**		**9**	**For**	
5	**For**		**10**	**For**	

Any medication allergies? If yes, please list.

FAMILY HISTORY: Has anyone in your family (grandparents, parents, siblings, children, living or deceased) been diagnosed with:

DISEASE / CONDITION		**WHO**	**DISEASE / CONDITION**		**WHO**
Retinal Detachment:	Yes/No		Blindness:	Yes/No	
High Blood Pressure:	Yes/No		Cataracts:	Yes/No	
Diabetes:	Yes/No		Glaucoma:	Yes/No	
Cancer:	Yes/No		Crossed Eyes:	Yes/No	
Heart Disease:	Yes/No		Macular Degen:	Yes/No	
Thyroid Disease:	Yes/No		Lupus	Yes/No	

PLEASE SHARE THE NAMES AND AGES OF YOUR HOUSEHOLD FAMILY MEMBERS:____

HOW DID YOU HEAR ABOUT OUR OFFICE?____

Reviewed by:

Dr ______________________________ Date ______________________________

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Patient Financial Information Sheet and Payment Policy

I understand that payment in full for services are due at time of service unless other arrangements have been made.

Name of Patient: ____ DOB: ___________

Main Member: ____DOB: ___________

If No Insurance Card is Available please supply the Insurance Carrier and ID #

Name of Primary Health Insurance Carrier: ____

ID/Policy#: ________________________________ Group #: __________________________

Name of Secondary Health Insurance Carrier: _______________________________________

ID/Policy#: ________________________________Group #: ___________________________

Name of Vision Insurance Carrier: ____

ID/Policy#: ________________________________Group #: ___________________________

<u>Authorization and Release:</u>

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health practitioners.

I authorize and request my insurance company to pay directly to the doctor insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

I authorize the release of any information including the diagnosis and the records of any treatment or examinations rendered to me or my child to: ___________________________

_____________________________________ _______________

Signature of patient or parent if minor Date

HIPAA Privacy Practice acknowledgement

I have received or was offered and declined a notice of privacy practices.

Signature: ____Date: ________________

Office Use Only: Insurance Card Copied? Yes _______ No_______ No Card ______

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It is the patient's responsibility to provide Kessler Optical with correct medical and vision benefit information. In the event that the correct information is not provided at the time of service, no claim will be filed for the services rendered and payment in full is required at the time of service. If the incorrect information is provided or we cannot establish eligibility, full payment is expected; additionally, you agree to release Kessler Optical of all responsibility for medical insurance or vision benefits claim filing.

- Spectacle orders require a minimum payment of TWO THIRDS to process the order.
- The balance is due in full at the time of dispensing the eyewear.
- 100% is due upon ordering if a vision plan claim will be filed.
- Payment in full is required for all contact lenses prior to ordering.
- There are no refunds on eyewear deposits.
- Hold deposits for eyewear are nonrefundable and will be credited to patient's account when the frame is returned to stock.
- Credit will be issued for undamaged frames returned to stock within 2 weeks of hold.
- Contact lenses are not returnable if boxes are opened, damaged or marked.
- It is the patient's responsibility to ask for the final return date on contact lenses.

Claims will be submitted for patients with vision or medical coverage if we are an in-network provider for the plan. However, we are not liable for collecting any claims. After 30 days, payment to Lawrence Kessler & Associates is expected in full. We accept all major credit cards, personal checks, money orders and cashier's checks. There is a $50 returned check fee. **All co-payments are due at the time of service. There is a $40 fee for no-show appointments or for appointments canceled with less than 24 hours' notice.**

Emergency medical visits

We require that emergency services are paid in full if we are unable to verify benefits with your medical insurance. Our office will submit a claim with your medical insurance; however, fees may be due on the day of treatment.

I HEREBY AUTHORIZE MY INSURANCE CARRIER TO MAKE PAYMENT DIRECTLY TO LAWRENCE KESSLER & ASSOCIATES FOR ANY OR ALL SERVICES RENDERED TO ME BY LAWRENCE KESSLER & ASSOCIATES. I HAVE READ, UNDERSTAND AND AGREE TO THE AFOREMENTIONED PROVISIONS AND TERMS.

Signature____ Date ____________

Parent (if minor) ____________________________________ Date____________

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