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:** Kessler Optical assigned parking is located across the street from our office, behind the Gold Rush pawnshop. These parking spots have Kessler Optical signage. If all of the spots are occupied, feel free to park at a meter. We are happy to validate your parking. Upon checking in we will provide you with coins. 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 refill the meter. DO NOT park in the parking lot next to Kessler Optical! It is not our parking lot and you will be towed. Kessler Optical is not responsible for towed vehicles.

- **Medical and Vision Benefits:** Dr. Kessler is a medical provider as well as a vision provider. He requires both types of insurance information on file. This is the only way we are able to verify the necessary information for your appointment. Please remember to bring benefit card(s) to your appointment.

- **Payment Options:** Kessler Optical accepts cash, checks, every major credit card, as well as FSA and HSA cards. Additionally, we accept Care Credit, which allows a 6-month no-interest payment plan, with a balance of $300.00 or more. www.carecredit.com

- **Paperwork and Insurance:** You will receive your "New Patient paperwork," via email. Please complete all documents, sign where required, and bring to your appointment. Dr. Kessler requires patients arrive 5-10 minutes prior to their scheduled appointment time. This allows time for our check-in process. Please remember to bring your HEALTH INSURANCE card, e.g., Health Alliance, BCBS etc.

- **Timeliness:** If you find that you will be late for your appointment please call. This allows us to make the necessary adjustments to Dr. Kessler's schedule.

- **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.

Occasionally there may be a wait due to emergencies or unforeseen complex cases. If you require a specific departure time please let our Front Desk Manager know, upon your arrival. We will do our best to accommodate your needs!

Again, we appreciate the confidence you have placed in us. We look forward to caring for your vision and overall eye health!

Sincerely,

Dr. Kessler and Staff

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		

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 ___ Fatigue Syndrome ___ Cancer ___ Developmental Disability ___ Other:	**Ear/Nose/Throat:** __ None ___ Dry Mouth ___ Laryngitis ___ Hearling Loss ___ Upper respiratory/Sinus	**Neurological:** __ None ___ 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 #: _____

Authorization and Release:

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.**

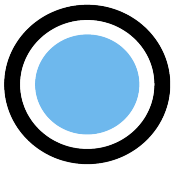
Emergency medical visits

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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Per Dr. Kessler, your overall Retinal health is important!

Macular Degeneration, Glaucoma, and Diabetic Retinopathy may cause partial and potentially permanent vision loss or blindness. Because these conditions are often asymptomatic, preventive testing and early detection are critical.

Painless and convenient, High Resolution Digital Retinal Photography is one of the means by which testing and early detection occur and may reduce the need for a dilated exam.

Dr. Kessler strongly advises annual Digital Retinal Photography for all of his patients. Regular and consistent testing make it possible for Dr. Kessler to document, review, and compare your Retinal health over time.

Your High Resolution Digital Retinal Photography test results are available immediately. Dr. Kessler will evaluate your photos and will discuss them, with you, during your appointment.

Vision plans provide a discount for this testing. Your out-of-pocket cost is $39.00.

Patient Signature _____ **Date** _____

Parent/Guardian _____ **Date** _____

$39 ACCEPT _____ DECLINE _____