The Deicke House
219 E Cole Avenue
Wheaton, IL 60188
(630) 690-7115

HIPAA-ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Spectrios Institute for Low Vision's Notice of Privacy Practices.

Patient Name: _____

Signature: _____

Date: _____

I authorize the following person(s) to have access to my Spectrios Institute records

Name: _____

Name: _____

Medicare/Insurance Information

Please complete this information sheet and bring it with you for your first appointment. This information will be necessary for Spectrios Institute for Low Vision at Deicke House to process your claim with Medicare, your supplemental insurance or commercial insurance carrier.

Please remember to bring your insurance cards with you to the appointment.

(Please Print)

Name_____

Date of Birth_____

Medicare Number_____

Is Medicare your primary insurance? YES NO

If Medicare is not your insurance, what is your primary insurance?

Please include name of carrier, Policy # and if you have an ID card please bring with you your appointment.

Patient Status: Single Married Widow Other_____

Employed: YES NO

I understand that Spectrios Institute for Low Vision is a participating provider of services. Spectrios Institute will bill Medicare, your Medicare supplemental insurance or commercial insurance carrier. I may be responsible for non-covered charges like deductibles, co-insurance amounts or non-covered charges. I will be billed for these non-covered charges after Medicare and my insurance carrier determines what is not covered under my plan.

Signature_____ Date_____

SPECTRIOS INSTITUTE FOR LOW VISION
ABN (Advanced Beneficiary Notice) Instructions

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We know that Medicare does not pay for ***any type of refractive services, non-optical and optical devices (i.e. magnifiers, telescopes and reading spectacles), electronic magnification devices, and any type of testing for driving purposes, including visual field testing for driving.***

Reason: This is because Medicare and other insurances exclude coverage for vision correction, vision rehabilitation devices and related services. Driving related assessments are not covered because driving is not considered medically necessary. For these reasons, you will have to pay for these services at the time the services is provided.

The costs of the services not covered by Medicare/Insurance are as follows:

• Complex Vision Rehabilitation Refraction	$75.00
• Driving Assessment	$265.00
• Driving Fields Only	$55.00

What you need to do now:

- Read the attached notice, so you can make an informed decision about your options.
- By selecting option 1 on the form, this allows us to submit to Medicare, and if denied allows you to contest the Medicare ruling.
- Please note, the costs listed above are out-of-pocket fees not covered by Medicare or other insurance plans.

Please read and sign the Medicare Advanced Beneficiary Notice of Non-coverage (ABN) form which we are required to provide you.

SPECTRIOS INSTITUTE FOR LOW VISION

A. Notifier: Spectrios Institute for Low Vision, 219 E. Cole Ave., Wheaton, IL 60187 P: 630/690-7115

B. Patient Name: **C. Identification Number: N/A**

Advance Beneficiary Notice of Non-Coverage (ABN)

NOTE: If Medicare doesn't pay for **D.** services listed below, you will be responsible for the charges. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** services listed below.

D.	E. Reason Medicare May Not Pay:	F. Est. Cost
1. Complex Vision Rehab. Refraction 2.	• Medicare and other insurances exclude coverage for vision correction, vision rehabilitation devices and related services.	1. $75.00
3. Occupational & Rehab Therapy 4.	• If you are currently receiving Home Health services, Medicare might not cover this service.	2. Varies
5. Driving Assessment		3. $265.00
6. Driving Fields Only		4. $55.00

WHAT YOU NEED TO DO NOW:

Read this notice, so you can make an informed decision about your care, let us know if you have questions. Choose an option below about whether to receive the **D. Services** listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

- ☐ **OPTION 1.** I want **D.** _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
- ☐ **OPTION 2.** I want **D.** _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.
- ☐ **OPTION 3.** I don't want **D.** _____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

Do you have insurance other than Medicare? If so, what is the name of that plan and you member number? _____

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

I. I. Signature:	J. Date:

SPECTRIOS INSTITUTE PATIENT MEDICATIONS LIST

Patient Name: _____Date: _____

Please provide a list of all medications you take including over the counter drugs, supplements and ocular medication/drops		
Name the Drug	**Strength**	**Frequency Taken**
Allergies to Medications		

Spectrios Institute for Low Vision
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(630) 690-7115

Release of Records Request
Phone: 630-690-7115 ext 123
Fax: 630-690-9037 attn: Patient Services

PLEASE PRINT ALL INFORMATION CLEARLY

Thank you for referring to Spectrios Institute.
Please provide the information below.
We will send you a visit summary after the patient has been seen.

Date: _____
Facility: _____
Referring Provider: _____
Phone: _____
Fax: _____

Patient Name: _____ **DOB:** _____

Signature _____

Address: _____

_____

Insurance Plan Name: _____

ID#_____**Group#**_____

HMO: Y/N **(if yes, please include authorization)**

****Diagnosis/Reason for Referral:** _____

Visual acuities: _____

Please forward progress notes and most recent visual field and fundus photos*

Date:

Spectrios Institute for Low Vision

Spectrios Institute for Low Vision is a **non-profit organization.** 60% of our operating costs depend upon grants, foundations and personal donations. **Many grantors require us to provide information about ethnic background and level of income for the people we serve.** Please help us by completing the following information.

No name is necessary and all information is confidential

One person family – annual income is:	☐ 0 - $17,800 ☐ $17,801 - $29,650 ☐ $29,651 - $35,580 ☐ $35,581 - $47,400 ☐ Over $47,401
Two person family – annual income is:	☐ 0 - $20,350 ☐ $20,351- $33,850 ☐ $33,851 - $40,620 ☐ $40,621 - $54,200 ☐ Over $54,201
Three person family – annual income is:	☐ 0 - $22,900 ☐ $22,901 - $38,100 ☐ $38,101 - $45,720 ☐ $45,721 - $60,950 ☐ Over $60,951
Family with more than 4 persons - List number_____ **List Annual Income$_____**	

ETHNICITY/RACE: (Check all that apply)

- ☐ White/Caucasian
- ☐ Hispanic/Latino
- ☐ African American
- ☐ Hispanic/Latino and other race
- ☐ Black/African American and White (write in other race)
- ☐ Asian
- ☐ Asian and White
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ American Indian/Alaskan Native
- ☐ Other Race:

Effective July 1, 2018