Colorado Eye Institute

board certified ophthalmologists and optometrists

New Patient Paperwork

Legal Name: _____ Date of Birth: _____

Sex: _____ Social Security Number: _____ Ethnicity: Hispanic or Latino / Not Hispanic or Latino / Decline

Race: Native American / Asian / African American / Caucasian / Pacific Islander / Other / Decline

Mailing Address: _____ City/State: _____Zip Code: _____

E-mail: _____ Primary Phone Number: _____

Secondary Phone Number: _____ O.K. to leave a detailed message? Y or N

If Minor, Parent/Guardian Name: _____ How did you hear about us? _____

Referring Provider/Primary Care Physician

Referring Provider/Phone Number: _____

Preferred Pharmacy/Location: _____

Emergency Contact

Name and Relationship: _____ Phone Number: _____

Patient/Parent Guardian: _____ Date: _____

*This authorizes the release of information to the above persons and providers.

Medical Insurance

*Please fill out in its entirety even if a copy of your cards are on file.

Primary Medical Insurance: _____ Subscriber's Name: _____
Subscriber's Date of Birth: _____ Subscriber's Social Security Number: _____

I.D. Number: _____ Group Number: _____

*For Tricare Patients: Tricare requires the social security number for the sponsor for billing.

Secondary Medical Insurance: _____ Subscriber's Name: _____

Subscriber's Date of Birth: _____ Subscriber's Social Security Number: _____

I.D. Number: _____ Group Number: _____

Payment Policy: The above information and an insurance card do not guarantee coverage. You are ultimately responsible for any payments on your account, including copays, co-insurances, deductibles, and non-covered services based on your plan and coverage. If you have questions about your insurance coverage, please reach out to your carrier.

Patient Signature: _____ Date: _____

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Financial Policy

Welcome to Colorado Eye Institute. We are pleased that you have chosen us to provide you with your ophthalmic care. Below are our policies regarding payment, referrals, and insurance with our office. Please read the following and inform us of any questions you may have.

- **Updating Insurance**: It is the patient responsibility to provide our office with their current medical insurance. If it has changed or not active on the day of your visit, you may be asked to reschedule or become financially responsible for the balance in full. We will not bill any visit after 90 days from the date of service, due to timely filling issues.
- **Copays, Deductibles, and Co-Insurances:** Patients are responsible for any amount not covered by their insurance, including deductibles, co-insurances, and copays. Copays are due at the time of service. *If your account becomes delinquent due to non-payment and is sent to a collection agency, you will be responsible for the charges incurred plus any costs involved.*
- **Self-Pay**: If a patient is uninsured or wishes to self-pay for their appointment, we offer a self-pay discount if services are paid in full at the time of service. The amount due for the service is dependent on what the provider bills and we are unable to provide an exact amount until after the service is provided. We can give an estimate based on the services being requested. We also offer payment plan's if needed.
- **Tricare and HMO insurance**: It is the patient's responsibility to understand their requirements of their insurance company. If your insurance requires a referral or authorization for any visit or service with our office, it is the responsibility of the patient to obtain this referral before the appointment. Failure to obtain required referrals or authorizations will result in the patient being financially responsible for the full balance.
- **Refraction**: The process of measuring your current glasses prescription and determining a new prescription that gives you the best vision possible. The refraction does not include any screening or examination and must be billed separately according to Medicare and insurance guidelines. *Many insurances including Medicare, Medicaid, Tricare, and most commercial medical insurance companies do not cover refraction and supplemental insurances may also deny payment. The fee for a refraction is $50.*
- **Late Policy:** If you arrive more than 10 minutes late to your appointment you will be asked to reschedule your appointment unless the doctor's schedule can accommodate you. *Priority will be given to patients who arrive on time, and you may have to be worked in between them*.

I have read and understand the payment policies set forth. I understand it is ultimately my responsibility to provide and understand my insurance to Colorado Eye Institute. It is my responsibility to satisfy any balances accrued on my account. I have and will provide, with the best of my ability, the accurate and complete billing information at each visit. By signing this document, I understand that I will be held responsible for any debts incurred.

Patient Signature: _____ Date: _____

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HIPPA Acknowledgement and Consent Form

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from designated third-party payers.
- Conduct normal healthcare operations such as quality assessments or evaluations and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information (copy available upon request in office). I have been given the right to review such Notice of Privacy Practices prior to signing this consent.

I understand that Colorado Eye Institute has the right to change its Notice of Privacy Practices from time to time and that I may contact Colorado Eye Institute at any time to obtain a current copy of the Notices of Privacy Practices.

I understand that I may request in writing that Colorado Eye Institute restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I understand that Colorado Eye Institute is not required to agree to my requested restrictions, but if Colorado Eye Institute does agree, then it is bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that the organization has taken action relying on this consent.

You may refuse to sign this consent.

Patient Name: _____Patient Date of Birth: _____

Patient or Legal Representative Signature: _____ Date: _____

Release of Information

I authorize the release of information, in accordance with HIPPA, including appointment times, the diagnosis, records, examination results, and claim information, to the following people.

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

Patient Signature: _____ Date: _____

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Patient Medical History

Patient Name: _____ Date of Birth: _____

Primary Care Physician: _____ Phone Number: _____

Please list any medications or eyedrops you are taking. We can also make a copy of a medication list if provided.

_____

Are you currently receiving treatment, or have you previously been treated for any of the following conditions? If so, please circle and explain in the right column.

Fever/Weight Loss	
Eyes Glaucoma / Cataract / Lazy Eye / Retina Problems / Corneal Problems / Laser Vision Correction / Other – Please Specify	
Cardiovascular Heart problems / Chest Pain / Irregular Heartbeat / High Blood Pressure / High Cholesterol / Other – Please Specify	
Respiratory Asthma / Shortness of Breath / Wheezing / Coughing / Other – Please Specify	
Gastrointestinal Heartburn / Abdominal Pain / Diarrhea / Vomiting / Other – Please Specify	
Integumentary Skin Rashes / Excessive Dryness / Other – Please Specify	
Musculoskeletal Muscle Aches / Joint Pain / Swollen Joints / Other – Please Specify	
Neurological Numbness / Weakness / Headaches / Paralysis / Other – Please Specify	
Hematologic/Lymphatic Blood Disorders / Leukemia / Other – Please Specify	
Allergic/ Immunologic Hay Fever / Allergies / Other - Please Specify	
Endocrine Thyroid Problems / Diabetes / Other - Please Specify	
Psychiatric Depression / Anxiety / Other - Please Specify	
Medical Allergies – Please Specify	

Family History: Do any medical or eye diseases run in your family? If YES, please circle and note relationship.

Glaucoma / Macular Degeneration / Diabetes / Cataracts / High Blood Pressure/ Other – Please Specify:

_____

Social History: Do you participate in any of the following? If YES, please circle and note frequency.

Smoking / Drugs / Drinking – Frequency: _____

Patient Signature: _____ Date: _____