the EYE CENTER of colorado
2480 S. Downing St. • Suite 100 • Denver, CO 80210
Phone: (303) 777.5455 • Fax: (303) 777.1175
frontdesk@eyecarecolorado.com

Welcome to The Eye Center of Colorado! Thank you for choosing us for your complete eye care needs. The following packet has been provided to help prepare you for your upcoming visit. In order to receive the most effective care, we ask that you bring the following with you to your initial appointment.

- Attached completed forms
- Medical and Vision insurance cards
- Drivers license or other form of photo identification
- Complete list of current medications; dosage and frequency
- Current eyeglasses
- If you wear contact lenses, please wear them to your appointment and bring the contact lens boxes
- If you require any type of special assistance please contact our office before the visit

New patient appointments take 1 to 2 hours. As part of a thorough new patient exam your eyes may be dilated. Dilation typically remains for 3-6 hours after your examination. During this time your near vision will be compromised and you will experience light sensitivity. Therefore, before leaving our facilities we will provide you with disposable sunglasses. Most people are able to drive following dilation, but you may want to bring a driver if you have experienced problems driving in the past, or if your eyes have never been dilated.

If your insurance requires that you have a referral from your Primary Care Physician, please call their office to obtain your referral prior to your appointment. Failure to obtain a referral could delay your appointment. All co-payments and any additional services not covered will be collected at the time of your appointment.

Please call your insurance should you have any questions regarding coverage. You will be held responsible for any fees not covered by insurance.

Please note: For all patients under the age of 18, a parent or legal guardian must accompany him or her.

We encourage you to visit our website at www.eyecarecolorado.com where you will find educational videos, frequently asked questions, and more.

To make your experience with The Eye Center of Colorado as efficient as possible, we ask that you complete the attached forms prior to your arrival. Should you have any questions for us prior to your visit, please do not hesitate to call. We look forward to meeting you soon.

Sincerely,

The Eye Center of Colorado

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Patient Registration Form

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PATIENT INFORMATION:

Last Name:	First Name:	MI:	Birth Date:

Address:	City:	State:	Zip:

Home Phone:	Cell Phone:

Email Address:	Age:	Sex ❑ M ❑ F	Social Security #

Occupation:	Employer:

Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced	Spouse's Name:

Language Preference:

REFERRAL INFORMATION:

Name of Family Physician:	Name of Optometrist:

How were you referred to our office?

PHARMACY:

Pharmacy:	Phone or Address:

Name Emergency Contact: Spouse / Son / Daughter / Brother / Sister / Friend / Other:	Phone:

What concerns about your eyecare would you like to have addressed?

Do you wear glasses? Yes / No	If yes, are they for distance / reading / computer:

Do you wear contact lenses? Yes / No	If yes, Name / Brand / Power:

Have you fallen in the last year? Yes / No	If so, did you need to seek medical attention? Yes / No

Do you have seasonal allergies? Yes / No	If yes, please describe:

Special considerations?

☐ Wheel chair ☐ Hearing Loss ☐ Memory ☐ Other:

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Medical Information Form

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Patient's Name: _____ Birth Date: ____/____/____

Age: _____ Height: _____ Weight: _____

Please ✓ if any of the following apply to you and the date it first occurred:

MEDICAL PROBLEMS

Condition	Please ✓	Date
Alzheimers	❑ Yes ❑ No	
Arthritis	❑ Yes ❑ No	
Asthma/COPD/Bronchitis	❑ Yes ❑ No	
Cancer – type _____	❑ Yes ❑ No	
Diabetes – type _____	❑ Yes ❑ No	
• What was your last A1C? _____	when?	
• What was your last glucose _____	when?	
High blood pressure	❑ Yes ❑ No	
Hepatitis/Jaundice	❑ Yes ❑ No	
Heart Disease	❑ Yes ❑ No	
Head Injury	❑ Yes ❑ No	
HIV positive/AIDS	❑ Yes ❑ No	
Kidney Disease	❑ Yes ❑ No	
Lupus	❑ Yes ❑ No	
Migraine Headaches	❑ Yes ❑ No	

Condition	Please ✓	Date
Rheumatic Fever	❑ Yes ❑ No	
Sarcoidosis	❑ Yes ❑ No	
Seizures	❑ Yes ❑ No	
Stroke	❑ Yes ❑ No	
Syphilis/Gonorrhea	❑ Yes ❑ No	
Thyroid Disease	❑ Yes ❑ No	
Tuberculosis	❑ Yes ❑ No	

Other Medical Problems (Please List)

_____
_____
_____
_____
_____
_____

SURGICAL HISTORY

Have you had **general** surgery? ❑ Yes ❑ No

Please list:

Surgery

Have you had **eye** surgery? ❑ Yes ❑ No

Please list (including laser and lid surgery):

Surgery	Date	Surgeon/Hospital

MEDICATIONS *(Please List)*

Name

Are you allergic to any medications, iodine, latex or anesthesia?

❑ Yes ❑ No If ***yes***, please list below:

_____
_____

FAMILY MEDICAL PROBLEMS

Do any family members have:	Please ✓	Relative
Glaucoma	❑ Yes ❑ No	
Macular Degeneration	❑ Yes ❑ No	
Diabetes	❑ Yes ❑ No	
Retinal Detachment	❑ Yes ❑ No	
Cataracts	❑ Yes ❑ No	
Amblyopia/Strabismus	❑ Yes ❑ No	
Other (list): _____		

SOCIAL HISTORY

Are you pregnant?	❑ Yes ❑ No
Do you smoke?	❑ Yes ❑ No
Do you drink alcohol?	❑ Yes ❑ No
Do you drink caffeine?	❑ Yes ❑ No
Do you use illegal drugs?	❑ Yes ❑ No
Do you use marijuana?	❑ Yes ❑ No

This is to certify that, I the undersigned, consent to examination and treatment. This information and any photography may be used for scientific and educational purposes. I hereby authorize The Eye Center of Colorado to furnish information to my insurance carrier, employer, referring physician, or other physician concerning my treatment and/or illness. I transfer assignment of all insurance benefits to The Eye Center of Colorado for services, treatment, supplies or surgeries provided by physicians or staff. I understand that **I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE.**

Patient Signature _____ **Date** _____

Medical Review Of Systems

the EYE CENTER of colorado

Patient Name _____ Birth Date _____

DO YOU CURRENTLY HAVE ANY PROBLEMS IN THE FOLLOWING AREAS?

Check ☑ Yes boxes only. No need to check ❑ No boxes.

EYES

Loss of Vision	❑ Yes	❑ No
Loss of Side Vision	❑ Yes	❑ No
Distorted Vision or Halos	❑ Yes	❑ No
Fluctuating Vision	❑ Yes	❑ No
Flashes	❑ Yes	❑ No
Floaters	❑ Yes	❑ No
Eye Pain or Soreness	❑ Yes	❑ No
Light Sensitivity	❑ Yes	❑ No
Double Vision	❑ Yes	❑ No
Crossing or Drifting of Eyes	❑ Yes	❑ No
Redness	❑ Yes	❑ No
Discharge	❑ Yes	❑ No
Foreign Body Sensation	❑ Yes	❑ No
Sandy or Gritty Feeling	❑ Yes	❑ No
Dryness	❑ Yes	❑ No
Itching	❑ Yes	❑ No
Burning	❑ Yes	❑ No
Excess Tearing/Watering	❑ Yes	❑ No
Glare	❑ Yes	❑ No
Styes	❑ Yes	❑ No

Other _____

CONSTITUTIONAL

Fever	❑ Yes	❑ No
Fatigue	❑ Yes	❑ No
Weight Loss	❑ Yes	❑ No
Weight Gain	❑ Yes	❑ No

SKIN

Rashes or Color Changes	❑ Yes	❑ No
Itching or Dryness	❑ Yes	❑ No
Hair or Nail Changes	❑ Yes	❑ No

EARS, NOSE, MOUTH & THROAT

Hearing Difficulty	❑ Yes	❑ No
Ringing	❑ Yes	❑ No
Vertigo	❑ Yes	❑ No
Sinus Congestion	❑ Yes	❑ No
Runny Nose	❑ Yes	❑ No
Post-Nasal Drip	❑ Yes	❑ No
Nosebleeds	❑ Yes	❑ No
Dry Throat/Mouth	❑ Yes	❑ No

CARDIOVASCULAR

Chest Pain	❑ Yes	❑ No
Palpitations	❑ Yes	❑ No

Other _____

RESPIRATORY

Cough	❑ Yes	❑ No
Shortness of Breath	❑ Yes	❑ No
Wheezing	❑ Yes	❑ No

GASTROINTESTINAL

Swallowing Difficulty	❑ Yes	❑ No
Vomiting	❑ Yes	❑ No
Heartburn	❑ Yes	❑ No
Diarrhea	❑ Yes	❑ No
Constipation	❑ Yes	❑ No
Nausea	❑ Yes	❑ No

MUSCULOSKELETAL

Joint Pain	❑ Yes	❑ No
Joint Swelling	❑ Yes	❑ No

NEUROLOGICAL

Headaches	❑ Yes	❑ No
Numbness	❑ Yes	❑ No
Tingling	❑ Yes	❑ No
Weakness	❑ Yes	❑ No
Paralysis	❑ Yes	❑ No
Fainting	❑ Yes	❑ No
Blackouts	❑ Yes	❑ No
Slurred Speech	❑ Yes	❑ No

PSYCHIATRIC

Anxiety	❑ Yes	❑ No
Depression	❑ Yes	❑ No

Other _____

ENDOCRINE

Heat Intolerance	❑ Yes	❑ No
Cold Intolerance	❑ Yes	❑ No
Excessive Thirst	❑ Yes	❑ No
Excessive Hunger	❑ Yes	❑ No

HEMATOLOGICAL

Easy Bruising	❑ Yes	❑ No
Easy Bleeding	❑ Yes	❑ No
Blood Transfusions	❑ Yes	❑ No
Swollen Lymph Nodes	❑ Yes	❑ No

Additional Notes/Comments:

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Patient Demographics

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PRIMARY INSURANCE

Name of Insurance:	ID Number:
Employer:	Group Number:
Who is the subscriber:	Do you need a referral?: ❑ Yes ❑ No
Subscriber's Date of Birth:	Subscriber's Social Security #:

SECONDARY INSURANCE

Name of Insurance:	ID Number:
Employer:	Group Number:
Who is the subscriber:	Do you need a referral?: ❑ Yes ❑ No
Subscriber's Date of Birth:	Subscriber's Social Security #:

VISION INSURANCE:

Name of Insurance:	ID Number:
Who is the subscriber:	Subscriber's Social Security #:

WORKMAN'S COMP. OR AUTO INSURANCE:

Where should bill be sent?:			Phone Number:
Address:	City:	State:	Zip:
Claim or Policy Number:			Date of Injury:

Patient Name: _____ **Date of Birth:** _____

Today's Date: _____

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NEW HIPAA PRIVACY REGULATIONS

Federal law, the Health Insurance Portability and Accountability Act of 1996, authorized the Department of Health and Human Services to adopt new rules to protect patient privacy.

Notification is therefore given that the office of The Eye Center of Colorado will not reveal to any person personal information about you or about a family member (i.e. name, address, Social Security Number, as well as other health information) without permission. Your information will never be sold, or listed for the purpose of advertisement, solicitation, or fundraising.

It is however understood, that within the realm of doing business and for general patient care purposes, your personal information will be necessary and used in the following context.

- Patient Registration
- Procure medical records from former physicians
- Converse with colleagues for opinions/care
- Insurance: verifications, Billing, paper and wire (including fax transmissions), Insurance company follow-up or interaction with billing services related to patient care
- Pursue collection of unpaid bills
- Hospital workers, nurses, aids, and medical records department
- Emergency officials, Paramedic, fire personnel, emergency room physicians, nurses or technicians
- Personal religious designate
- Pharmacists, drug program personnel/workers
- Completion of disability forms
- Computer and electronically stored information (i.e. related business vendor and service persons)

I AUTHORIZE THE RELEASE OF THIS NECESSARY INFORMATION

_____
Print Name

_____ _____
Signature of Patient or Representative Date

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Medical Services Financial Disclosure Agreement

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Please Review

Effective as of Thursday, March 1st, 2018

Insurance

If you have medical or vision insurance, we are eager to help you receive your maximum allowable benefits. In order to achieve this goal we need your assistance and your understanding of our payment policy.

You will be asked to update your personal and insurance information periodically, including providing our office with copies of your current insurance card. We are required by law to obtain your signature for permission to release information to your insurance carrier. Please assist us in complying with your insurance requirements.

Refraction Policy

Some insurance companies do not cover the refraction portion of an eye exam. The refraction is the portion of the eye exam that determines your glasses prescription and/or whether your vision has changed. This is an essential part of the exam; however some insurance companies do not include the refraction as a covered expense. **Please be prepared to pay the $45.00 refraction fee today in addition to your copay** (if applicable).

Payment for Services

Payment for service, including co-payments and deductible amounts are due at the time services are rendered unless payment arrangements have been approved in advance by our staff.

Returned checks will result in a $25 fee that will be posted to your account. Returned checks, account balances older than 60 days, and failure to pay account balances as promised may be subject to external collection and additional collection fees.

Cancelled Appointments

Failure to not show or cancel a scheduled appointment less than **24 hours** in advance will result in a **$40.00** fee.

General

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. **Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. We must emphasize that as medical care providers, our relationship is with you, not your insurance company. While filing of insurance claims is a courtesy that we extend to patients, all charges are your responsibility from the date services are rendered.**

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in managing your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask. Thank you.

My electronic signature constitutes acknowledgement and acceptance of this policy.

Please sign at Check-in Counter

Patient Name (please print) Date

Thank you!

Patient or guarantor signature Date

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HIPAA Authorization for Release of Patient Information

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Patient (print) _____ DOB _____ ☐ M ☐ F

Phone number (_____) _____ day (_____) _____ evening

Release TO: The Eye Center
2480 S. Downing St., Ste 100
Denver, CO 80210
(303) 777-5455 phone
(303) 777-1175 fax

Release from: _____

Address: _____

Phone (_____) _____

fax (_____) _____

I request and authorize the release of information to the organization, agency, or individual named above. I understand that the information to be released may include the following condition(s):

- **Drug Abuse/Alcohol Abuse (Fed. Reg. 42 C.F.R., Part 2)**
- **Psychological or psychiatric conditions**
- **A test for the presence of antibodies (HIV) virus which causes AIDS**
- **An AIDS diagnosis and/or an AIDS related condition**
- **Any third party source (hospital, specialist office, lab)**

According to Colorado State Statutes (GCCR 1101-1, Rule XIV), there is a charge for copies of medical records. The charge is $14.00 for the first 10 pages, $.50/pages 11-39, and $0.33/pages 40 and above.

Information requested (Please mark the box for all items you authorize to be released):

☐ Most recent History and Physical
☐ Third party record
☐ Laboratory results
☐ Visual Field
☐ OCT
☐ Operative report
☐ Other _____
☐ Progress notes
☐ Pathology reports
☐ MRI results
☐ Ct results
☐ Contact/Glasses Rx

Treatments date(s): _____

Purpose of release: ☐ Eye surgery ☐ Other _____

I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the Site Practice Manager. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____ .
I certify that this request has been made voluntarily. This authorization is subject to written revocation at any time, except to the extent that action has already been taken to comply with it. In any event, this authorization expires ninety (90) days from the date of signature. I release the above from liability and claims of any nature pertaining to the disclosure of requested information contained in my medical records. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

_____ _____
Signature of patient **Date**

_____ _____
Witness **Signature of legal guardian/executor**

If patient is unable to sign, please document reason: _____

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POS Reorder # 1802819