EYE CENTER OF THE ROCKIES

Welcome To Our Office!

Patient Information

Date: _____

Patient Name: _____ Sex: ☐M ☐F

Mailing Address: _____

City: _____ State: _____ Zip: _____

Physical Address: _____

City: _____ State: _____ Zip: _____

Social Security Number: _____ Date of Birth: _____ Age: _____

☐Married ☐Widowed ☐Single ☐Separated ☐Divorced ☐Partnered

Spouse's Name: _____ Parent Names (if Patient is a Minor): _____

Home Phone #: _____ Cell Phone #: _____
Occupation: _____ Employer: _____
Work Phone #: _____
Best time and place to reach you: _____
Email Address: _____

____I do not want automated appointment reminders by phone. _____ (patient initials)

Part Time Resident's Non-Colorado Address:

Address: _____ City: _____
State: _____ Zip Code: _____ Home Phone #: _____

IN CASE OF EMERGENCY, CONTACT
Name: _____ Relationship: _____
Phone: _____

REFERRED BY: _____

PRIMARY CARE PHYSICIAN: _____

HMO Insurance Policies

EYE CENTER OF THE ROCKIES IS *NOT* IN NETWORK WITH ANY HMO INSURANCE PLANS. If you have an HMO insurance policy as your primary insurance, we are ***not*** in network and you will be required to pay for your services.

If Medicare is your Primary Insurance carrier and you have an **HMO insurance policy as your Medicare secondary insurance**, your HMO secondary insurance most likely won't pay the 20% not covered by Medicare. In this event, you are responsible for the 20% not covered by Medicare.

Cancellation / No Show Policy

We value your time and we hope you value ours as well. We have instituted new *No Show* and *Cancellation* Fees as Follows:

Effective immediately, we will now require 24 hours notice of appointment cancellation. Should you miss an appointment, or fail to notify us 24 hours prior to the scheduled appointment of cancellation, we will not reschedule another appointment without a deposit of $45. We will require a credit card to schedule the next appointment. Your card will NOT be charged unless you fail to keep this next appointment or again cancel with less than 24 hours notice.

Print Patient Name: _____

Patient / Parent Signature: _____ Date: _____

Patient Intake – Health Summary

Patient Name: _____ **DOB:** __/__/____
(Please Print)

Allergies: None: _____

ALL Current Medications: None: _____

Men Only: Do you currently take, or have taken in the past these medications for enlarged prostate and urinary flow?

Medication	Yes	No
Tamsulosin or Flomax (brand name)		
Alfuzosin or Uroxatral (brand name)		
Silodosin or Rapaflo (brand name)		

Review of Systems

	Yes	No	Explanation of problem
Eyes (blur, red, pain, etc)			
General (fever, weight loss, fatigue, etc.)			
Cardiovascular (hypertension, racing pulse, heart disease, etc.)			
Respiratory (asthma, congestion, wheezing, etc.)			
Gastrointestinal (stomach ulcers, intestinal disease, hernia, etc.)			
Genital, Kidneys, Bladder (painful or freq. urination, impotence, prostate etc.)			
Neurological (numbness, headache, etc.)			
Psychiatric (anxiety, depression, insomnia)			
Endocrine (Diabetes, Thyroid, etc.)			

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Blood, Lymphatic (high cholesterol, anemia, etc.)			
Skin (pimples, warts, growths, rash, etc.)			
Allergic, Immune (sneezing, itching, etc.)			
Muscle, Bones, Joints (joint pain, swelling, cramps, arthritis, etc.)			

ALL Surgeries

	Yes	No	Explanation
Cataracts - Right Left			
LASIK/ PRK - Right Left			
Detached/Torn Retina – Right Left			
Cornea Transplant – Right Left			
Other General surgeries			

Family History

Illness/ Disease	Yes	No
Macular Degeneration		
Glaucoma		
Diabetes		
Cancer		

Other History

Smoking – yes___ no ___ **Do you drive?** – yes___ no ___

Alcohol – yes___ no ___ **Do you have problems with night vision?** – yes___ no ___

Patient Signature: _____ **Date**: ___/___/_____ **Tech Initials**:_____

Reviewed on: ___/___/___ **Tech Initials**:_____

Reviewed on: ___/___/___ **Tech Initials**:_____

A. Notifier: Matthew Ehrlic. .D

B. Patient Name: _____ **C. Identification Number:** _____

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** Refraction test below, you may have to pay. 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.** Refraction test below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
1. Physician examination for eye glasses prescription.	1. Medicare has determined that the refraction test is not medically necessary.	1. $45.00
2. Physcian examination for contact lens prescription and fitting(s)	2. Medicare may not cover contact lenses.	2. Between $150.00-$165.00

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** Refraction 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 the **D.** Refraction test 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 the **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 the **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:

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. Signature:	J. Date:

EYE CENTER OF THE ROCKIES

Patient Billing Policies & Insurance Consent

Financial Responsibility

I understand that I am **financially responsible** for **ALL CHARGES** whether or not paid by insurance. ***This includes any amounts applied towards my deductible or co-pays by the insurance company.*** Copayment is expected at time of service. A $50.00 return check fee will be charged on all checks returned for insufficient funds in addition.

Once we have received payment in full from your primary insurance (and secondary if you have additional coverage), You will receive a statement for the patient-owed portion of the bill. Balances are due ***IN FULL*** at this time. An interest charge will be added for a partial payment. These balances are usually unpaid copayments, deductible amounts or non-covered benefits. (note that balances can change due to multiple dates of service, tests etc.)
It is the policy of this office to send ***THREE STATEMENTS.*** The statements are sent at 30-day intervals. If no payment is received on your account during the 90-day period, a collection letter will be mailed. If no payment is received after 30 days then your account will be turned over to a collections service ***without additional notice.*** At this time, you will be responsible for all costs of collection, including but not limited to interest, rebilling fees, court costs, attorney fees and other collection agency costs. The collection agency used by Eye Center of the Rockies is Red River Collections. They can be reached at 303-316-0209.

Insurance benefits

I also understand that it is my responsibility to know the benefits and coverage requirements of my insurance carrier for special procedures and regular office visits. I authorize the use of my signature on all insurance claims and the release of any information necessary to process claims.

Insurance Verification/Precertification

I understand Dr. Ehrlich's office may verify my insurance coverage or call the insurance company for pre-certification/authorizations/notifications/pre-determinations but this does not guarantee payment by the insurance company. Any estimates given from these insurance verification/precertification phone calls are **not quotes** and I will be responsible for any amounts due after the insurance company processes the claim. This includes office visits, procedures and/or surgery. I am aware that some procedures and surgeries may have pathology involved and I will be responsible for all associated fees. Any amount owed after insurance processing cannot be written off due to our contractual agreement with the insurance companies. I understand that I am responsible for knowing what my insurance company will pay and will call to verify payment coverage prior to any of my office visits, procedures or surgeries.

I understand they my signature on this form acknowledges my understanding of this policy. We thank you for choosing Eye Center of the Rockies for your eye care.

PLEASE CHOOSE ONE:

☐ I certify that I have insurance coverage with _____ (name of insurance company) and I hereby authorize payment of medical benefits to Eye Center of the Rockies for all services rendered.
☐ I certify that I DO NOT have any insurance and that I am **financially responsible** for **ALL CHARGES which are due to be paid in full at the time of service.**

Print Name: _____ Date of Birth: _____

Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THE INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Overview

The law requires us to keep your protected health information ("PHI") private in accordance with this Notice of Privacy Practices ("Notice"), as long as this Notice remains in effect. We are also required to provide you with a paper copy of this Notice, which contains our privacy practices, our legal duties, and your rights concerning your PHI.

From time to time, we may revise our privacy practices and the terms of our Notice at any time, as permitted or required by applicable law. Such revisions to our privacy practices and our Notice may be retroactive. Our Notice will be updated and made available to our patients prior to any significant revisions of our privacy practices and policies.

Our Privacy Practices

Use and Disclosure. We may use or disclose your PHI for treatment, payment or health care operations. For your convenience, we have provided the following examples of such potential us of disclosures.

Treatment. Your PHI may be used by or disclosed to any physicians or health care provider involved with the medical services provided to you. Payment. Your PHI may be used or disclosed in order to collect payment for the medical services provided to you. Health Care Operations. Your PHI may be used or disclosed as part of our internal health care operations. Such healthcare operations may include, among other things, quality of care audits of our staff and affiliates.

Authorizations. We will not use or disclose your medical information for any reason except those described in the Notice, unless you provide us with a written authorization to do so. We may request such an authorization to do so. We may request such an authorization to use or disclose your PHI for any purpose but you are not required to give us such authorization as a condition of your treatment. Any written authorization from you may be revoked by you in writing at any time, but such revocation will not affect any prior authorized uses or disclosures.

Patient Access. We will provide you with access to your PHI, as described below in the Individual Right section of this Notice. With your permission, or in some emergencies, we may disclose your PHI to your family members, friends, or other people to aid in your treatment or the collection of payment. A disclosure of your PHI may also be made if we determine it is reasonably necessary or in your best interests for such purposed as allowing a person acting on your behalf to receive filled prescriptions, medical supplies, etc.

Locating Responsible Parties. Your PHI may be disclosed in order to locate, identify, or notify a family member, your personal representative, or other person responsible for your care. If we determine in our reasonable professional judgment that you are capable of doing so, you may be given the opportunity to consent to or to prohibit or restrict the extent or recipient of such disclosure. If we determine that you are unable to provide such consent, we will limit the PHI disclosed to the minimum necessary.

Required by Law. We may use or disclose your medical information when we are required to do so by law. For example, your PHI may be released when required by privacy laws, workers' compensation or similar laws, public health laws, court or administrative orders, subpoenas, certain discovery requests, or other laws, regulations or legal processes. Under certain circumstances, we may make limited disclosures of PHI directly to law enforcement officials or correctional institutions, regarding the inmate, lawful detainee, suspect, fugitive, material witness, missing person, or victim or suspected victim of abuse, neglect, domestic violence or other crimes. We may disclose your PHI to the extent reasonably necessary to avert a serious threat to your health or safety of the health or safety of others. We may disclose your PHI when necessary to assist law enforcement officials to capture a third party who has admitted to a crime against you or has escaped from lawful custody.

Deceased Persons. After your death, we may disclose your PHI to a coroner, medical examiner, funeral director, or organ procurement organization in limited circumstances.

Military and National Security. We may disclose to military authorities the medical information of Armed Forces personnel under certain circumstances. When required by law, we may also disclose your PHI for intelligence, counter intelligence and other national security activities.

Your Individual Rights

Access and Copies. In most cases, you have the right to review or copies of your PHI by requesting access or copies in writing to our office. Additional Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your PHI, but we are not required to honor such a request. We will be bound by such restrictions only if we agree to do so in writing.

Complaints

If you believe we have violated your privacy rights, you may complain to us or the Secretary of U.S. Department of Health and Human Services. You may file a complaint with us by notifying our office manager. We support your right to protect the privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or the U.S. Department of Health and Human Services.

NOTICE OF PRIVACY PRACTICES/ACKNOWLEDGMENT OF RECEIPT: I acknowledge receiving Eye Center of the Rockies, P.C.'s "Notice of Privacy Practices", which provides information about how Eye Center of the Rockies, P.C. may obtain, use and disclose my protected health information.

I certify that I have read the foregoing and I am the patient, the patient's legal representative, or otherwise duly authorized by the patient to sign and accept its terms on his/her behalf.

Signature: _____ Date: _____
(Responsible party)

If signed by person other than the patient, indicate relationship to patient: _____

IF THE ABOVE PATIENT IS OVER 18 YEARS OF AGE, we need permission to speak to anyone OTHER than the patient regarding PHI.

I authorize Eye Center of the Rockies, P.C to disclose my health information to the following person(s):

Name: _____ Phone: _____
Relationship: _____

Name: _____ Phone: _____
Relationship: _____

Name: _____ Phone: _____
Relationship: _____

Signature of Patient: _____ Date: _____