New Patient Information

Demographics:

Today's date: _____

Patient name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____ Gender: _____

Social Security # (required by insurance): _____

Cell phone: _____ Home phone: _____ Work phone: _____

Race/Ethnicity: _____ Preferred Language: _____

Employer: _____

Name of Referring Physician: _____

Name of Primary Care Physician: _____

Responsible Party □ Self □ Spouse □ Parent □ Other

Responsible Party Name: _____ Phone: _____

Date of birth: _____ Social Security #: _____

In case of emergency, please notify: _____

Relationship: _____ Phone: _____

Preferred Pharmacy:

_____

Address: _____

Phone #: _____ Fax #: _____

Current Medications:

Name: _____ Dosage: _____ Frequency: _____

Name: _____ Dosage: _____ Frequency: _____

Name: _____ Dosage: _____ Frequency: _____

Name: _____ Dosage: _____ Frequency: _____

Name: _____ Dosage: _____ Frequency: _____

Name: _____ Dosage: _____ Frequency: _____

Name: _____ Dosage: _____ Frequency: _____

Name: _____ Dosage: _____ Frequency: _____

Name: _____ Dosage: _____ Frequency: _____

Name: _____ Dosage: _____ Frequency: _____

Name: _____ Dosage: _____ Frequency: _____

Medication Allergies:

❑ No Known Drug Allergies

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Acknowledgment of Authorization, Consent to Treatment, Privacy Statement, and Assignment of Benefits

Authorization for Release of Protected Health Information

Release Information to me:

Where can we contact you? □ **Home** □ **Work** □ **Cell**

Springs Eye Consultants may release Protected Health Information to me by calling me at the preceding phone numbers I may have provided to the practice.

Where can we leave you a voice mail? □ **Home** □ **Work** □ **Cell** □ **None**

Springs Eye Consultants may release Protected Health Information to me by leaving a voice mail at the preceding numbers I may have provided to the practice.

Release of Medical Information to others:

Who can we release your information to?

Should it become necessary, Springs Eye Consultants' physicians and medical staff have my permission to discuss my health information, including test results, with the individuals listed below. The following people below are also authorized to schedule, confirm, cancel or reschedule an appointment for me.

□ **Do not release my information to others.**

Name: _____ Relationship: _____

Phone: _____ □ Home □ Work □ Cell

Name: _____ Relationship: _____

Phone: _____ □ Home □ Work □ Cell

Privacy Statement:

I have been offered a copy of the Notice of Privacy Practices for Springs Eye Consultants. I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 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 among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by Springs Eye Consultants that its' Notice of Privacy Practices contains a more detailed description of the uses and disclosures of my health information. I understand that I have the right to review this Notice of Privacy Practices prior to signing this consent. I understand that Springs Eye Consultants reserves the right to change its Notice of Privacy Practices and that I may obtain any revised notices at the office.

With my signature, I consent to the use and disclosure of my protected health information by Springs Eye Consultants for the purposes of treatment, payment, and healthcare operations. I understand that I retain the right to revoke this consent in writing at any time, except to the extent that Springs Eye Consultants has already taken action in reliance on this consent.

Authorization For Treatment

I authorize the physicians and staff of Springs Eye Consultants to perform procedures necessary to assess and diagnose my condition, and to perform treatments as may be prescribed by my physician. I understand that I am financially responsible for all charges for services rendered to me by the physicians and staff of Springs Eye Consultants

I understand that having my eyes dilated is an important part of my eye exam. Dilation involves putting eye drops into the eyes to enlarge the pupils. This allows the doctor to get a better view of the inside of my eyes to detect any problems.

I understand that dilation can cause temporary blurring of vision and sensitivity to light. The blurring can affect my ability to drive or operate machinery. The light sensitivity can be mitigated by wearing sunglasses, which will be provided by the clinic. I understand that these effects usually last for a few hours, but can last longer in some cases, especially in people with lighter colored eyes. I give my consent to have my eyes dilated.

I understand the process of surgical co-management. Co-management is a relationship between an operating ophthalmologist and a nonoperating practitioner for shared responsibility in the postoperative care when the patient consents to multiple providers, the services being performed are within the providers' respective scope of practice and there is agreement between the providers to share patient care. I consent to co-management or transfer of care for one of the following reasons: inability to travel due to distance or the development of another illness, lack of availability of the person(s) or organization previously responsible for bringing the patient to the operating ophthalmologist's office, the operating ophthalmologist will be unavailable to provide care (e.g. travel, leave, itinerant surgery in a rural area, to minimize cost of travel, loss of time spent traveling, patient

inconvenience, personal patient considerations such as comfort with the non-operating practitioner doctor-patient relationship, provided that the operating ophthalmologist is familiar with the nonoperating practitioner's skills, their qualifications, and their compliance with their states specific scope of practice and licensure. I understand that I may contact the operating ophthalmologist at any time after the surgery.

Authorization and Assignment of Benefits

I authorize the release of any medical or other information necessary to process the insurance claim(s) for services rendered by Springs Eye Consultants. I request payment of government benefits, if applicable, to the party who accepts assignment. I authorize payment of medical benefits to Springs Eye Consultants. I understand that even though I may have insurance coverage, I am ultimately responsible for payment of the services rendered. It is my responsibility to notify the organization of any changes in my health care coverage.

Surprise Billing, Appointments, Credit Card, and Financial Policy

Surprise Billing Notice

Beginning January 1, 2020, Colorado state law protects you from "surprise billing". This is sometimes called "balance billing" and it may happen when you receive covered services, other than ambulance services, from an out-of-network provider in Colorado. This law does not apply to all health plans and may not apply to out-of-network providers located outside of Colorado. Check to see if you have a "CO-DOI" on your ID card; if not, this law may not apply to your health plan.

What is surprise/balance billing and when does it happen?

You are responsible for the cost-sharing amounts required by your health plan, including copayments, deductibles and/or coinsurance. If you are seen by a provider or use services in a hospital or other type of facility that are not in your health plan's network, you may have to pay additional costs associated with that care. These providers or services at hospitals and other facilities are sometimes referred to as "out of network".

Out-of-network hospitals, facilities or providers often bill you the difference between what [Carrier] decides is the eligible charge and what the out-of-network provider bills as the total charge. This is called 'surprise' or 'balance' billing.

When you CANNOT be balance-billed:

<u>Emergency Services</u>

When you receive services for emergency medical care, usually the most you can be billed for emergency services is your plan's in-network cost-sharing amounts, which are copayments, deductibles, and/or coinsurance. You cannot be balanced-billed for any other amount. This includes both the emergency facility and any providers you may see for emergency care.

Non-emergency services at an In-Network or Out-of-Network Facility

The hospital or facility must tell you if you are at an out-of-network location or at an in-network location that is using out-of-network providers. It must also tell you what types of services may be provided by any out-of-network provider.

You have the right to request that in-network providers perform all covered medical services. However, you may have to receive medical services from an out-of-network provider if an in-network provider is not available. When this happens, the most you can be billed for covered services is your in-network cost sharing amount (copayments, deductibles, and/or coinsurance). These providers cannot balance bill you.

Additional Protections

Your insurer will pay out-of-network providers and facilities directly. Again, you are only responsible for paying your in-network cost-sharing for covered services.

Your insurer will count any amount you pay for emergency services or certain out-of-network services (described above) toward your in-network deductible and out-of-pocket limit.

Your provider, hospital, or facility must refund any amount you overpay within 60 days of you reporting the overpayment to them.

A provider, hospital, or other type of facility cannot ask you to limit or give up these rights.

If you receive services from an out-of-network provider, hospital or facility in any OTHER situation, you may still be balance billed, or you may be responsible for the entire bill. If you intentionally receive non-emergency services from an out-of-network provider or facility, you may also be balance billed.

If you do receive a bill for amounts other than your copayments, deductible, and/or coinsurance, please contact us at the number on your ID card, or the Division of Insurance at 303-894-7490 or 1-8009303745.

Ambulance Information: You may be balance billed for emergency ambulance services you receive if the ambulance service provider is a publicly funded fire agency, but state law against balance billing does apply to private companies that are not publicly funded fire agencies. Non-emergency ambulance services, such as ambulance transport between hospitals, are not subject to the state law against balance billing, so if you receive such services and they are not a service covered by your insurance, you may receive a balance bill.

Appointment No-Show, Cancellation, and Dismissal

For Office Visit:

An appointment missed without prior notification (at least 24 hours in advance) is classified as a “no-show” appointment. A fee of $50.00 will be applied for no-show appointments. However, allowances may be made for illness or other circumstances, which will be evaluated on an individual, case-by-case basis.

For Procedure:

Patients who fail to attend their scheduled surgical procedure, or do not provide notification to the office at least 48 hours prior to the appointment, will incur a cancellation fee of $75.00.

Dismissal from Practice:

Patients who miss three or more appointments within a 12-month period may be advised to seek care with another medical practice, a measure intended to enhance their ability to adhere to scheduled appointments.

The cancellation and no-show fees are patient responsibility and must be paid in full before the patient's next appointment. I have read and understand these policies.

Authorization for Credit Card on File

I authorize Springs Eye Consultants to securely retain my credit card information should I also provide verbal consent when I provide my credit card information to the practice. My credit card will only be charged when I provide verbal consent to do so.

FINANCIAL POLICY

We are committed to providing you with the highest level of service and quality care. If you have medical insurance, we will strive to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our financial policy. Ultimately, however, any and all financial liability rests with the patient.

Our office participates with most major insurance plans. We provide medical surgical ophthalmologic care, and routine eye exams to our patients. We do not participate with vision plans like VSP. Typically, vision plans require the doctor's office to sell glasses in order to participate. If you have a managed care plan that requires a referral to see a specialist, you must obtain a referral in order for your visit in our office to be covered under your medical insurance. If you do not have the valid referral and still wish to be seen, you will be asked to pay for the visit prior to your examination. A refractive examination or refraction is not a covered service by medical insurance companies, including Medicare. If you receive a prescription for glasses, you will be charged $50 which is payable at the time of the visit.

I understand that some services may be considered non-covered services by my insurance plan. It is my responsibility to know what my insurance does or does not cover and I understand that I am financially responsible for paying all non-covered services. Some charges may be denied by my insurance carrier as investigational, experimental or not medically necessary and will not be paid by my insurance carrier. I understand that my physician feels these services are needed whether my insurance carriers deem them payable or not and that I am obligated to pay for these services in full should I choose to accept the services.

If the practice is not a participating provider in my insurance plan, I will be responsible for filing my own claims and I will be responsible for paying in full at the time of service. The practice only accepts patients that have only

Medicaid coverage if they are referred by another Eye Care Provider for a medical condition. The practice does not participate with Medicaid for routine vision services. I understand that I am responsible for my copay at the time of service and if I have exceeded my yearly allotted visits that I am responsible for paying for my visit in full at the time of service. Some insurance plans require you receive a prior authorization for services by a specialist, please review your policy to see if there is such a requirement and obtain this authorization prior to your visit with our clinic.

It is the patient's/parent's/guardian's responsibility to be familiar with the benefits of your plan, including co-pays, co-insurance and deductibles. Please bring all of your current insurance cards to all visits. Please provide our office with current information including address, phone numbers and employer. In accordance with your insurance contract, you must be prepared to pay your co-pay at each visit. If you do not make your co-payment at the time of the visit, you may be charged an additional $30 billing fee. We accept cash, checks and all major credit cards for services.

We appreciate prompt payment in full for any outstanding balance. If your account is turned over to our collection agency, you agree to pay any fees imposed by the collection agency in order to collect the overdue amount. Any check payments that do not clear the bank will be subject to a $50.00 returned check fee. There is a charge for completing various forms, including your DMV form. Pre-payment is required for completing forms, or for extra written communication by the doctor. The charge is determined by the complexity of the form, letter, or communication.

For all services rendered to minor/dependent patients, we will look to the adult accompanying the patient and/or the parent or guardian with whom the child resides for payment. In cases of separation or divorce, when presenting insurance cards for a dependent enrolled under a subscriber other than you, please be prepared to supply their name, address, phone number, date of birth and social security number. We request that you inform the subscriber that their insurance has been used.

I acknowledge the above polices.

Print name: _____

(If a patient is a minor or dependent, parent or legal guardian must print name)

Signature: _____ Date: _____

(If a patient is a minor or dependent, parent or legal guardian must sign)