RetinaSpecialists OF COLORADO

Today's Date:

Demographic Information	
Patient Name:	Date of Birth:
Referring Doctor:	Sex:
Home Phone:	Social Security #:
Cell Phone:	Email:
Street Address:	City, St, Zip:
Emergency Contact Name:	Emergency Contact Relationship:
Emergency Contact Phone:	

Insurance Information
Primary Insurance Company:
Insurance Member ID:
Name of Policy Holder (If not Self):
Date of Birth of Policy Holder (If not Self):
Relation to Patient:
Secondary Insurance Company:
Insurance Member ID:
Name of Policy Holder (If not Self):
Date of Birth of Policy Holder (If not Self):
Relation to Patient:

Retina Specialists of Colorado
1444 S. Potomac St #175
Phone: 720-443-2425
Fax: 720-328-5369

RetinaSpecialists OF COLORADO

MEDICAL HISTORY

Allergies:

_____

Medical History:

_____

_____

_____

_____

Current Medications:

_____

_____

_____

_____

Eye/Ophthalmic History:

_____

_____

_____

_____

Eye Surgeries (and approximate dates):

_____

_____

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Other Surgeries (and approximate dates):

_____

_____

Family Medical History:

_____

_____

_____

_____

Family Eye History:

_____

_____

_____

_____

History of Kidney/Renal Disease (specify): YES NO

History of Hepatitis: YES NO Type of Hepatitis: _____

History of HIV: YES NO

History of COVID-19: YES NO Date: _____

History of COVID-19 Vaccination: YES NO

SOCIAL HISTORY

Smoking: YES FORMER NO Packs per day:_____

Alcohol Use: YES NO Drinks per day:_____

Drug Use: YES NO Type: _____

Are you pregnant: YES NO

ADDITIONAL INFORMATION

Retina Specialists of Colorado is a retinal medical practice. All patients will have both eyes dilated unless otherwise recommended by the doctor. Dilating drops make your eyes more sensitive to light and decrease the ability to accommodate or see small letters or focus on objects that are near. Dr. Chod and Dr. Jansen caution all patients against driving a motor vehicle until dilating drops have worn off; to do so would be at my own risk.

SIGNATURE (PATIENT) _____ DATE _____

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ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

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 for the purposes of conducting and coordinating care, obtaining payment, and supporting healthcare operations of Retina Specialists of Colorado.

I acknowledge that I have received the Notice of Privacy Practices, which provides a comprehensive explanation of how my protected health information may be used or disclosed. I was given the opportunity to review the notice prior to signing this consent.

I understand that Retina Specialists of Colorado has the right to change its Notice of Privacy Practices from time to time, and that I may contact this organization at anytime to obtain the most current copy of the Notice of Privacy Practices.

I understand that I may request in writing restrictions on the use or disclosure of my protected health information. I also understand that Retina Specialists of Colorado is not required to agree to my requested restrictions, but are bound to abide by such restrictions upon agreement.

I understand that I may revoke my consent to use and disclose my protected health information upon written request. Any use or disclosure that has already occurred prior to the date of revocation request is received will not be affected.

As per HIPAA, Retina Specialists of Colorado reserves the right to decline service if the consent form is not signed.

I HAVE READ AND UNDERSTAND THIS CONSENT. I CONSENT TO THE USE AND DISCLOSURE OF MY HEALTH INFORMATION IN ACCODANCE TO THE NOTICE OF PRIVACY PRACTICES.

_____

Name of Patient (Please Print)

_____

Signature of Patient Date

_____

Signature of Patient Representative

_____

Relationship of Patient Representative to Patient Date

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Print Name: _____

FINANCIAL ASSIGNMENT AND AGREEMENT

INSURANCE

We are participating providers with several insurance plans. Our policy is to bill insurance as a courtesy for all of our patients. In order to bill your insurance claims correctly for all appointments, we require that you provide a copy of your current insurance card, social security numbers of the patient and responsible party, a picture ID (such as a driver's license or identification card,) and a current mailing address that matches the address on file with your insurance carrier. If you cannot provide your insurance card, you must pay for your visit in full at the time of service. If prior authorization or unique claim forms are required, it is your responsibility to obtain this prior to your visit.

It is important to remember that insurance is a contract between the patient and the insurance company, and ultimately the patient is responsible for payment in full. If your insurance company does not pay the practice within a reasonable period of time, you will be billed. If we later receive payment from your insurer, we will refund any overpayment to you.

PATIENT RESPONSIBILITY

Any fees collected at the time of service and any quotes regarding such fees are estimated based on the information available to us at the time of service. We rely on information provided by the responsible party regarding insurance coverage. If the insurance information you provide is incorrect, you will be responsible for payment of the visit and submitting charges to your insurance company for reimbursement.

We can never guarantee that your insurance will cover all services or administered medications, even if verified, until our office receives the actual explanation of benefits (EOB.) It is best for you to understand your insurance plan before services and/or products are delivered to prevent misunderstanding.

PAYMENT

All copayments, deductibles, and coinsurance amounts are due at the time of service. It is our policy to render periodic statements for services and products on a monthly basis. Any account balance that is not paid in full within 60 days of the due date (i.e. the date of service) may be forwarded to an outside agency for collections. All costs of collections, including attorney fees, collection fees of 30% and court costs are the responsibility of the patient. Any unpaid balance will be assessed interest at the rate of 18.00% (1.5% monthly.) Insurance claims are filed to patient insurance companies as a courtesy, but it is the patient's responsibility to see that the claims are paid on time. Any account balance that remains unpaid after transfer to a collections agency may be eligible for reporting to a credit bureau.

For your convenience, we accept cash, check, money orders, debit cards, and most credit cards.

Returned checks will incur an additional $25 fee.

WAIVER OF PATIENT RESPONSIBILITY

It is the policy of the practice to treat all patients in an equitable fashion related to account balances. The practice will not waive, fail to collect, or discount co-payments, co-insurance, deductibles, or other patient financial responsibilities in accordance with federal and state law, as well as participating agreements with payers.

_____

Initials

RetinaSpecialists OF COLORADO

PATIENTS WITH HMO OR POS INSURANCE PLANS STATEMENT

As a member of an HMO or POS insurance plan, I am aware that I am required to bring my insurance card and obtain a referral in order to receive benefits for specialty care from Retina Specialists of Colorado. If I do not have a valid referral or authorization from my insurance company, I understand that I am fully responsible for all charges incurred. Without a valid referral, financial responsibility will lie upon the patient and full payment will be due at the time of service.

RELEASE

I hereby authorize Retina Specialists of Colorado, its doctors, and/or agents to apply for reimbursement benefits on my behalf for services rendered to me. I understand that payment from my insurance carrier will be made directly to Retina Specialists of Colorado. I further authorize the release of any information necessary, including but not limited to any medical information, in order to process any claim with my insurance carrier. I understand that I am financially responsible for all charges, including those not covered by my health insurance. I further understand that I will be responsible to pay for any service denied by my insurance company. I authorize the use of this signature on all insurance submissions. I understand that I am responsible for all co-payments, deductibles, co-insurance, non-covered services, and/or amounts exceeding any maximum benefits outlined by my insurance plan and that such payments are due at the time of service. I understand that in the event my insurance company does not pay for services rendered by Retina Specialists of Colorado, I agree to accept full financial responsibility for any direct or ancillary charges for services rendered on behalf of myself and/or my dependents.

I have read, understand, and agree to the Financial Policy Statement above in its entirety.

_____

Print Name

_____ _____

Patient/Responsible Party Signature Today's Date

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