NEW PATIENT FORMS

Today's Date ___________

Patient – Complete all sections and pages of the New Patient Forms. Read through the below policies and disclosures, then sign/date where notated. Please bring these completed forms to your initial appt, along with a valid photo ID, medical insurance card(s), and specialist copay.

PATIENT INFORMATION

Last Name________________________ First Name_______________________ MI_______

Preferred Name ___________________________ Sex: M ____ F ____ Age _________

Date of Birth (*mm/dd/yyyy*) _____ /_____ /________ Social Security # _____ - ______ -________

Home Phone ______ - ________ - __________ Cell Phone ______ - _______ - __________

Email ____

Address_________________________ City _____________ State_________ Zip __________

Preferred contact method: Phone___ Text___ Email___ May we leave a message: Y____ N____

Employer Name ____________________________ Occupation _________________________

Marital Status: S___ M___ D___ W___ Spouse Name (*if applicable*) ______________________

Preferred Language: English ____ Spanish ____ Other (*list*) _________ __________________

Race (*check one*)

___ American Indian/Alaska Native	___ Native Hawaiian/Pacific Islander
___ Asian	___ White
___ Black/African American	___ Unknown or Other

Ethnicity (*check one*)

___ Hispanic or Latino
___ Not Hispanic or Latino
___ Unknown or Other

WORKER'S COMP INFORMATION (*if applicable*)

Works comp related injury? Y____ N____ Work Comp Carrier __________________________

Date of Accident (*mm/dd/yyyy*) ______ /______ /________ Claim # ________________________

Contact Name _______________________ Contact Phone ______ - ________ - __________

RERFERRING PROVIDER INFORMATION

Reason for Visit ____

Referring Eye Doctor __________________________ Phone # ______ - _______ - __________

Office Name/Address ____

Primary Care Physician (PCP) ________________________ Phone # _____ - ______ - ________

Office Name/Address ____

FRONT OFFICE USE ONLY:
Front Office Initials _______
Date Received ___________

FINANCIAL POLICIES

The following information is provided to help you understand our financial policies and aid you in planning for payment. The financial policies detailed below are a condition of receiving care in our practice.

Insurance

Please bring your insurance card(s) with you when you visit our practice as we need a copy for your chart. It is your responsibility to ensure we have your current insurance information on file so we can submit a claim to them for payment on your behalf. We participate with all major insurance carriers and most insurance plans; however, it is your responsibility to confirm with your insurer that Colorado Retina Associates is participating with your plan. You can do so by calling the Member Services phone number listed on the back of your current insurance card.

Co-pays

Co-pays are due when you check in at our front desk for your appointment. We accept cash, check, VISA, Mastercard, American Express and Discover. We may charge a $25.00 billing convenience fee on copays not paid at the time of service. Convenience fees are not covered by insurance, and you will be fully financially responsible for paying them.

Returned Checks

All returned checks are assessed a $30 Returned Check Fee. It is important you resolve returned checks promptly or we may send your account to an outside collection agency.

No-Shows and Late Cancellations

Kindly provide us with at least 24 hours' advance notice if you are unable to keep an appointment.

Injectable Medications

If the medication for your injection is ordered through a specialty pharmacy, you will need to pay the pharmacy for the medication in advance of your appointment or your appointment will be rescheduled.

Financial Responsibility

If insured, you are financially responsible for payment of your deductible, co-pay, co-insurance, and any amount exceeding what your insurance company pays, except where exempt by contractual agreement. You are responsible for complying with any requirements your insurance carrier may have regarding referrals, and it is your responsibility to ensure we have a valid referral on file if required by your plan.

FINANCIAL POLICIES CONTINUED

Self-Pay
If you are "Self-Pay" because you don't have health insurance or opt not to utilize your health benefits, you are financially responsible for payment in full at the time of service unless you have made other arrangements in advance of receiving care.

Patient Balances
We send patient statements monthly and your payment is due upon receipt. If we don't receive your payment or a phone call from you to set up payment arrangements, you may not be allowed to schedule future appointments and your account may be sent to an outside collection agency. We will pass any fees charged by the outside collection agency on to you. In the unfortunate event we must seek legal assistance to obtain your payment for services rendered, we will pass associated legal fees on to you.

Financial Hardship
We offer several payment options, including payment plans and discounted care. Care may be discounted up to 100% under qualifying circumstances. Being considered for discounted care requires an application, proof of income, and copies of tax returns and bank statements. You can request an application by calling our Billing Department at (303) 261-1592.

Assignment of Benefits
You hereby authorize payment of your health insurance benefits (and, if applicable, government benefits) directly to Colorado Retina Associates for healthcare services we have provided to you.

Notice of Privacy Practices
I have received a copy of the Notice of Privacy Practices for Protected Health Information. I understand that Colorado Retina Associates can use or disclose my personal health information to carry out treatment, payment, or healthcare business operations as described in the Notice of Privacy Practices for Protected Health Information.

Acknowledgement:
I HAVE READ THE ABOVE FINANCIAL POLICY AND/OR IT HAS BEEN FULLY EXPLAINED TO ME AND I UNDERSTAND ITS CONTENTS.

Print Patient's Name: ____

Today's Date: ________________________________

X____

SIGNATURE of Guarantor/Responsible Party (primary on insurance)

If Legal Representative, provide relationship to Patient: ______________________________

PATIENT REQUEST FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient or Legal Guardian Name (print) ____

I authorize Colorado Retina Associates to release/discuss/schedule personal health information and/or financial information for ____________________________________(patient name) to my following family members and/or privileged contacts:

EMERGENCY CONTACTS

Emergency Contact #1

Name______________________________ Phone (______) _______ - _________

May we leave a Message? Y____ N____

Emergency Contact #2

Name______________________________ Phone (______) _______ - _________

May we leave a Message? Y____ N____

Emergency Contact #3

Name______________________________ Phone (______) _______ - _________

May we leave a Message? Y____ N____

Acknowledgement: I understand that this authorization will remain in effect until I give written notice of termination to Colorado Retina Associates.

Print Patient's Name: ____

Today's Date: ______________________________

X____

SIGNATURE of Guarantor/Responsible Party (primary on insurance)

If Legal Representative, provide relationship to Patient: ______________________________