NEW PATIENT FORMS

COLORADO RETINA

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 _____

COLORADO RETINA

FINANCIAL POLICIES

Thank you for choosing Colorado Retina Associates as your health care provider. While your health and well-being are our primary concern, we realize that the cost of healthcare is an issue for many patients. We offer the following information to help you understand our financial policies and aid you in planning for payment. Carefully review the information and please ask our staff if you have any questions. 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.

COLORADO RETINA

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.

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 Legal Name: _____

Today's Date: _____ / _____ / _____

Signature: _____

If Legal Representative, provide relationship to Patient: _____

COLORADO RETINA

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: _____