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

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.

Medicare: Our doctors are participating with Medicare. We will be happy to submit any claims to Medicare and any medigap claims one time for you. If you do not have any secondary or supplemental coverage, you will be responsible for the 20% of what Medicare does not cover. There are certain tests and/or procedures that Medicare does not cover of which you will be notified and will be responsible for payment at the time of visit.
Medicaid: Our doctors are participating with Medicaid; we will file claims for you. You will be expected to pay any co-pays at the time of your visit.
HMO & PPO: We will file claims for you if we are participating with your plan. You will be responsible for any co-pays, deductibles, or services not covered at the time of your visit. If your plan requires a referral/ authorization from your primary care physician, you will be responsible for obtaining this prior to your visit.
Private Pay: You will be responsible for payment in full the day of service.

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 with 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 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.

Patient Balances
We send patient statements monthly and your payment is due upon receipt. If we do not 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.

INSURANCE SIGNATURE AUTHORIZATION
In cases for which insurance claims are filed the following form should be completed. For us to submit a claim on your behalf and request payment of insurance benefits either to myself or the party who accepts assignment, I understand that I, the patient, am financially responsible for bills submitted and for any balance not paid by insurance. A copy of this signature is as valid as the original.

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:____ Date:_____________________

Signature:____

If Legal Representative, provide relationship to patient:______________________________________

APPENDIX A
NOTICE OF PATIENTS' PRIVACY RIGHTS

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. PURPOSE OF THIS NOTICE

Our Practice is committed to maintaining the privacy of your protected health information (PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We are also required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our Practice concerning your PHI. By federal and state law, we must follow the terms of this Notice of Patient's Privacy Rights ("Notice") currently in use by the Practice.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI;
- Your privacy rights in your PHI; and
- Our obligations concerning the use and disclosure of your PHI.

The terms of this Notice apply to all records containing your PHI that are created or retained
by our Practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this Notice will apply to all your records that our Practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our Practice will post a copy of our current Notice in our offices in a
visible location at all times, and you may request a copy of our most current Notice at any
time. Our Practice will always follow the Notice that is in effect at the time any action related to PHI is taken.

II. <u>**If you have questions about the Notice, please contact:**</u> Medical Records or Compliance departments.

III. <u>**DIFFERENT WAYS THE PRACTICE MAY USE AND DISCLOSE YOUR MEDICAL INFORMATION:**</u>

A. Treatment. Our Practice may use your PHI to treat you. For example, we might use your PHI to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our Practice, including, but not limited to, our doctors, nurses, and technicians, may use or disclose your PHI to treat

you or to assist others in your treatment. Additionally, with your authorization, we may disclose your PHI to others who may assist in your care, such as your spouse, children, or parents, collectively called your “Friends and Family List,” as documented by you on your “Patient Authorization for Use and Disclosure of Protected Health Information” form. To let us know with whom you want your information shared, please be sure to complete this notice. Finally, we may also disclose your PHI to other healthcare providers for purposes related to your treatment.

B. **Payment.** Our Practice may use and disclose your PHI to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such service costs, such as family members. Also, we may use your PHI to bill you directly for service and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts. You have the right to request that our Practice not submit a claim to your insurance company for payment due to privacy concerns. However, you agree to pay for all services in full under the time frame specified by our Practice. Failure to do so constitutes a waiver of this right (see ‘Requesting Restrictions’ below).

C. **Healthcare Operations.** Our Practice may use and disclose your PHI to operate our business. As examples of the way in which we may use and disclose your information for operations, our Practice may use your PHI to evaluate the quality of care you receive from us, or to conduct cost-management and business planning activities for our Practice. We may disclose your PHI to other healthcare providers and entities who are involved with your healthcare to assist in their healthcare operations.

D. **Disclosure to You.** Our Practice may disclose your medical information to you or a third party to whom you request us in writing to disclose your medical information.

E. **Release of Information to Family and Friends.** With your authorization, our Practice may release your PHI to a friend or family member that is involved in your care, or who assists in take care of you. Generally, we require written authorization to share your PHI with friends and family members.

F. **Disclosures Required by Law.** Our Practice will use and disclose your PHI when we are required to do so by federal, state, or local law.

G. **Disclosures to Business Associates**. Our Practice may contract or otherwise arrange with other entities to perform services. System may then disclose your medical information to these “Business Associates,” and these Business Associates will use or disclose your medical information only to the extent the Practice would be able to do so.

These Business Associates are also required to comply with federal law that regulates your medical information privacy.

H. **Limited Data Set**. The practice may use or disclose your medical information for purposes of healthcare operations, research, or public health activities if the information is stripped of direct identifiers and the recipient agrees to keep the information confidential.

IV. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION IN CERTAIN CIRCUMSTANCES:

A. **Health Oversight Activities.** Our Practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure, and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws, and the healthcare system in general.

B. **Lawsuits and Similar Proceedings.** Our Practice may use and disclose your medical information to persons authorized by law to receive the information under a court order, subpoena, discovery request, warrant, summons, or similar process. Requests for your medical information from an attorney involving civil litigation must be accompanied by your signed authorization.

C. **Law Enforcement.** We may release your PHI if asked to do so by a law enforcement official if they need the information to investigate a crime or to identify or locate a suspect, fugitive, material witness, or missing person.

D. **Serious Threats to Health or Safety.** Our Practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

E. **Military.** Our Practice may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

F. **National Security.** Our Practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal officials to protect the President, other officials, or foreign heads of state, or to conduct investigations.

G. **Inmates.** Our Practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (1) for the institution to

provide healthcare services to you; (2) for the safety and security of the institution; and/or (3) to protect your health and safety or the health and safety of other individuals.

H. **Workers' Compensation.** Our Practice may release your medical information to comply with workers' compensation laws or similar programs providing benefits for work-related injuries or illnesses.

I. **Governmental Agencies.** Our Practice may release your medical information to agencies authorized to receive reports of abuse if you are a victim of abuse, neglect, or domestic violence.

J. **Coroners/Medical Examiners/Funeral Directors**. Our Practice may release PHI after your death to identify you, to determine your cause of death, or as otherwise authorized by law.

K. **Health and Human Services**. Our Practice will release your PHI to the federal agency that investigates compliance with federal privacy law.

V. YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION:

1. **Right to Confidential Communication.** You have the right to request that our Practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must indicate in writing on the (APPENDIX E) specifying the requested method of contact and/or the location where you wish to be contacted. Our Practice will accommodate reasonable requests. You do not need to give a reason for your request.

2. **Right to Request Restrictions.** You have the right to request a restriction in our use or disclosure of your medical information for treatment, payment, or healthcare operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. To request a restriction on our use or disclosure of your PHI, you must make your request in writing to (APPENDIX K). Your request must be described in a clear and concise fashion:
   - The information you wish is restricted.
   - Whether you are requesting to limit our Practice's use, disclosure, or both; and
   - To whom you want the limits to apply.

3. **Right to Inspect and Copy.** You have the right, in most cases, to inspect and copy your medical information maintained by or for the Practice. You must make your request in writing to the Privacy Officer. If the Practice denies your request, you may have the right

to have the denial reviewed by a licensed health care professional selected by the Practice. If the Practice (or a licensed health care professional performing the review on behalf of the Practice) grants your request the Practice will provide you with the requested access. You may request copies of such information; however, but our Practice may charge you a reasonable fee.

4. **Right to Amend.** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our Practice. To request an amendment, your request must be made in writing and submitted to the Privacy Officer. You must provide us with a reason that supports your request for amendment. Our Practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion (1) accurate and correct; (2) not part of the PHI kept by or for the Practice; (3) not part of the PHI that you would be permitted to inspect; or (4) not created by our Practice, unless the individual or entity that created the information is not available to amend the information.

5. **Right to an Accounting of Disclosures.** (APPENDIX F) You have the right to request a list of disclosures of your medical information that have been made by the Practice. To obtain an accounting of disclosures, you must submit your request in writing to the Privacy Officer. All requests for an "accounting of disclosures" must state a period, which may not be longer than six (6) years from the date of disclosure. The first list you request within a 12-month period is free of charge, but our Practice may charge you for additional lists within the same 12-month period. Our Practice will notify you of other costs involved with additional requests, and you may withdraw your request before you incur any costs. The Practices does not have to list disclosures:
    1. for treatment, payment, or healthcare operations;
    2. of a limited data set for healthcare operations, research, or public health activities;
    3. to you and individuals involved in your healthcare;
    4. to authorized federal officials for national security activities;
    5. that occur incidentally with other permissible uses and disclosures;
    6. made under your written authorization; and
    7. law enforcement officials or health oversight agencies.

6. **Right to a Paper Copy of This Notice**. You are entitled to receive a paper copy of our Notice of Privacy Practices. You may ask us to give you a copy of this notice at any time. To obtain a copy of this notice, contact: Medical Records, Front Desk, or Compliance departments.

7. **Right to File a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with our Practice's Privacy Officer or with the federal government's Department of Health and Human Services. To file a complaint with our Practice, contact

our Privacy Officer. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

8. **Right to Provide an Authorization for Other Uses and Disclosures.** Our Practice will obtain your written authorization for uses and disclosures that are not identified by this Notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note we are required to retain records of your care. If you have any questions regarding this Notice or our health information privacy policies, please contact our Privacy Officer.

VI. BREACH NOTIFICATIONS

Our Practice makes every effort to secure your health information, including the use of encryption whenever possible. If any of your medical information that has not been encrypted is the subject of a breach, our Practice will provide you with a written or electronic notification about the breach as required by federal law.

Michelle Wagner
Privacy Officer
Colorado Retina
255 S. Routt St, ste: 200
Lakewood, CO 80228

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGMENT FORM:

I, ____, have received a copy of the Notice of Privacy Practices.

Signature of Patient: _________________________________ Date: _________________

Signature of Guardian: _______________________________ Date: _________________

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: ______________________________