COLORADO WEST OPHTHALMOLOGY ASSOCIATES, P.C.
PATIENT INFORMATION

(Please Print)

PERSONAL INFORMATION

Today's Date_____

Name _____ _____ _____
(Last) (First) (MI)

Mailing Address_____ City_____ State_____ Zip_____

Home Address _____ City_____ State_____ Zip_____

Home Phone _____ Cell Phone _____ E-mail_____

Date of Birth _____Social Sec # _____ Male [ ] Female [ ]

Name of employer (if applicable)_____Work Phone_____

Race: White/ Other/ Asian/ Black-African Am/ Am Indian- Alaskan Nat/ Hawaiian-Other Pacific Island

Ethnicity: Hispanic-Latino/ Non-Hispanic-Latino/ Unknown

Language: English/ Spanish/ French/ German/ Italian/ Portugese/ Japanese/ Russian

Preferred Communication: (**choose one**) Home phone/ Work phone/ Cell phone/ E-mail/ Text. If choosing E-mail or Text, we will give you our Web-Portal information.

PERSONAL PHYSICIAN: _____ REFERRED BY:_____

Billing Information For Responsible Party/ Guardian (<u>if the patient is a minor</u>)

Name _____ Social Security No._____
Address_____ City_____ State_____ Zip_____
Daytime Phone _____ Relationship to Patient_____ Date of Birth_____

Name of employer_____
Address_____City_____ State_____ Zip_____
Phone _____

If you are in Hospice or Rehabilitation-Please inform the receptionist

If this is Workman's comp or Auto Accident-Please inform the receptionist

INSURANCE INFORMATION (be sure to bring your cards)

<u>Name of Primary insurance</u> _____
Policy holder's name (**if other than self)** _____Date of Birth _____

<u>Name of Secondary insurance</u> _____
Policy holder's name (**if other than self**)_____Date of Birth _____

Policies of Colorado West Ophthalmology Associates, P.C.

Please read and initial below **Patient name**_____
Printed

_____ I acknowledge being given access to this practices HIPPA Privacy Policies (located in waiting room).

_____ I authorize this practice to release financial or medical information to facilitate my treatment and to submit my insurance claims. I understand payments will be made to Colorado West Ophthalmology Associates P.C.. If I do not have insurance, payment should be made at the time of service. If I have insurance, a claim will be submitted on my behalf. Co-pays and non-benefit services should be made at the time of service. Once the remaining balance has been billed to me, it is due within 30 days. If I am unable to pay the full amount, I should contact your office to make payment arrangements.

_____ **Any unpaid amount over 30 days will be considered past due. We will add a $30.00 late fee per month** unless you have made monthly payment arrangements. Accounts over 60 days with no payments will receive a final notice and be given 2 weeks to pay. If payment is still not received, the account will be turned over to a collection agency, which may result in damage to your personal credit. All collection agency fees, late fees and interest are charged to the patient.

_____Insurances have timely filing rules. All insurance information needs to be given to us within 30 days of the visit for a claim to be submitted. If not received in time, I will be responsible for the charges.

_____ Colorado West Ophthalmology is **not a provider for any "vision service plans",** even though they may be a provider of my medical plan. If I have a "VSP" plan, I agree to pay for the visit.

_____ I accept financial responsibility for charges not covered by my insurance, including Medicare and Medicaid (i.e., Co-pays, deductibles, **and Non-benefit charges, including the REFRACTION CHARGE *(*test to determine if there is a need for corrective lenses or to receive a glasses Rx). If you do not want this test done, PLEASE INFORM THE TECHNICIAN**.

_____ If my insurance requires a **REFERRAL,** I will obtain it before my visit. If a required referral is not received, I will pay at the time of service.

_____ Colorado West Ophthalmology asks that you cancel/reschedule appointments 24 hours in advance. After the 2nd occurrence, if no attempt to cancel is made, a fee of $25.00 may be assessed. This fee is not covered by insurance.

OVER

Due to privacy rules, if you want anyone other than yourself to call with questions about your appointments, billing, and medical information, you will need to list them below. (ie.. spouse, children, parent, grandparent etc. this is not for release to a doctor)

Name:_____Relationship_____Phone_____

Name:_____ _Relationship_____Phone_____

Name:_____ _Relationship_____Phone_____

Emergency contact if different from above_____Phone_____

The undersigned certifies that he/she is the patient or the duly authorized representative of the patient, and agrees to these terms.

_____**Date**_____

(Signature of Patient, or Parent, or other person authorized to consent for a patient)