



Welcome to Colorado Cataract & Laser Center!

Welcome to Colorado Cataract & Laser. It is our goal to provide you with the best experience possible when it comes to your eye health needs. We want your appointment to focus on YOU and deliver your eye care needs in the most efficient manner possible.

To accomplish this goal we ask you to be our partner in this process. Please help us in filling out the necessary personal and medical history information on line with our easy-to-use Patient Portal. Please arrive 20 minutes early with your benefits and current insurance cards.

We ask this so WE can prepare for your visit and when you show up, we can be 100% focused on patient care and your eye health needs, whether that be for a simple routine exam or helping you best understand your medical eye conditions.

To give the best care for our patients, we would appreciate your cooperation with the following policies:

- Our practice utilizes an **automated messaging system** that delivers a personalized text and phone message to you including your name, date, time, and location of your appointment.
- It is the policy of our practice to charge a \$35.00 “no show” fee if you have an appointment and do not call to cancel it. CCL has this policy so we can accommodate ALL patients, stay on time, and account for the time we prepare for your visit with us.
- If you are over 15 minutes late for your appointment you might be asked to reschedule.

Please bring the following with you to your appointment. Without this information, your appointment may be delayed or rescheduled.

- **Current list of all medications and dosages.** If you are not sure of the dosages or cannot read the prescription labels, please bring the actual medications with you to your first appointment.
- If you currently **wear glasses**, bring them with you.
- **Bring your insurance cards.** For our insurance records, we will copy them and keep them in your medical record. Should your insurance carrier require a referral, please bring one with you.
- Please be prepared to **pay your specialist co-pay** at time of service.

Please review *Our Financial Policy* that is included with this packet. We participate with many insurance plans and we will bill them as a courtesy to you.

Colorado Cataract & Laser Center Clinic Staff



PATIENT DEMOGRAPHIC FORM

Today's Date: _____

Patient Name: _____
 F

Date of Birth: _____ Age: _____ Sex: M

Address: _____

Marital Status: S M D W O

City: _____ State: _____ Zip: _____

Cell Ph#: _____ Work Ph#: _____

Employer Name: _____

Workers Comp: Y N

Employer Address: _____

Auto Accident Y N If yes, what State?

City: _____ State: _____ Zip: _____

PERSON WHO SIGNS CONSENT AND IS RESPONSIBLE FOR BILL

SELF

Insured (Responsible) Party Name: _____

Relationship to Patient: _____

Address: _____

Date of Birth: _____ SS#: _____

City: _____ State: _____ Zip: _____

Home Ph#: _____ Work Ph#: _____

INSURANCE INFORMATION

Primary Insurance: _____

Phone: _____

Group #: _____ Subscriber/SS#: _____

Pt. Relation to insured: Self Spouse

Child Other

Do you have Secondary Insurance? Y N

Secondary Insurance: _____

Phone: _____

Group #: _____ Subscriber/SS#: _____

Pt. Relation to insured: Self Spouse

Child Other

I hereby assign payment directly to The Colorado Cataract & Laser Center, **BASIC BENEFITS** and/or **MAJOR MEDICAL** (catastrophe) **BENEFITS** herein specified and otherwise payable to me but not to exceed the regular charges for this period of treatment. I understand I am financially responsible for any charges not covered by this assignment.

I understand that upon discharge I may request, in writing, a copy of my records.

I have read, understand and signed Colorado Cataract & Laser Center *Financial Policy* and the *Notice of Privacy Practices*.

Signed: _____

Dated: _____

Insured and/or Responsible Party

Consent for Treatment

I hereby consent to such treatment procedures and patient care which, in the judgment of my physician and/or provider, may be considered necessary or advisable while a patient at Colorado Cataract & Laser Center. I also understand that Colorado Cataract & Laser Center may use my patient treatment data for quality assurance and research purposes, and that my name or identity will not be connected with the data.

Signed: _____

Dated: _____

Insured and/or Responsible Party



FINANCIAL POLICY

Welcome to the Colorado Cataract & Laser Center ("CCLC"). We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy that we require you to read and sign prior to any treatment.

EYEGGLASS PRESCRIPTION (REFRACTION): I understand that refractions a service that is not covered by Medicare or most health insurance carriers. If your doctor provides a refraction with an eyeglass and/or contact prescription, you will be responsible for this charge, which is payable at the time of service.

REGARDING INSURANCE

We will gladly bill your insurance company directly if you have provided us with all the necessary information to do so. Your contract for health insurance is between you and your insurance company. We are not a party to that contract. The services that you receive and the bill, is an agreement between you and CCLC. It is ultimately your responsibility to see that your bill is paid in full. Agreements with insurance companies vary greatly and it is your responsibility to know what is their portion and what is yours. Any remaining money unpaid by your insurance company will be your responsibility to pay in a timely manner. If your insurance company does not begin paying CCLC within 5 weeks, it will be your responsibility to contact them. You will be notified by mail of the balance due on your account, and you may request a statement of account if necessary. It will reflect what your insurance company, upon verification, told us is your portion to pay. We expect this payment within 15 days. If payment is not received within this 15-day period, a finance charge of 1.5% will be assessed per month. In the event a check is returned for any reason, a \$25.00 charge will be made to your account.

Many insurance companies require a referral from your Primary Care Physician (PCP) to a specialist prior to any appointment. It is your responsibility to ensure that this referral is obtained prior to all scheduled appointments. To obtain a referral you will need to contact your PCP and request one. Failure to have a referral on file in our office prior to your appointment will require a waiver and payment in full at the time of service, or for the appointment to be rescheduled.

REGARDING INSURANCE PLANS WHERE WE ARE A PARTICIPATING PROVIDER: All co-pays and deductibles are due prior to treatment. In the event that your insurance coverage changes to a plan where we are not participating providers, refer to the above paragraph. If you receive payment made out to both CCLC and you, please endorse the check and forward to us.

MEDIGAP AUTHORIZATION (IF APPLICABLE)

The following is to be filled out if you have a Medigap insurance policy for which you wish to assign benefits. A Medigap or Medicare supplement policy is a health insurance policy or another health plan, offered by a private company, to those entitled to Medicare benefits. It is designed to pay certain costs that Medicare does not pay. By law, this excludes a policy or plan offered by an employer to employees or former employees, as well as a policy or plan offered by a labor organization to member of former members.

PAYMENT FOR SERVICES

Payment is due in full at the time of service for those without insurance coverage. All payment arrangements must be made in advance with the business office at 303-337-3937. If we bill your insurance and reimbursement is 100% denied, we will bill you our Self Pay rates plus an 18% per annum service charge. If you are unsure of self pay rates, it is your responsibility to ask. If you are a cash pay patient and you do not pay at the time of service or an arrangement to be billed by our billing department has not been set-up, you will be charged an 18% per annum service charge. On occasion, certain procedures may not be reimbursed by your insurance company. If it is expected that insurance will not cover, payment is due at the time of service.

NO SHOW & LATE CANCELLATION

If you are unable to attend, YOU MUST NOTIFY THE CLINIC AT LEAST 8 HOURS IN ADVANCE AND RESCHEDULE TO MAKE UP THE MISSED APPOINTMENT. It is the policy of CCL to charge the patient a \$35.00 'no show' fee if they have an appointment and do not call to cancel it.

I have read the Financial Policy. I understand and agree to this Financial Policy. I acknowledge the receipt of The Colorado Cataract & Laser Center's HIPAA Notice of Privacy Practices.

Signed: _____ Dated: _____

Is there anyone involved in your care, or payment of your care with whom we may share your medical information?

[] Yes [] No If Yes, person's name: _____ Relationship: _____

COLORADO

CATARACT & LASER

MEDICAL HISTORY FORM

Date: _____

Patient Name: _____

Age: _____

Sex: F M

Date of last eye exam: _____

Date of last physical exam: _____

Check all reasons for your visit today: _____

	RIGHT EYE	LEFT EYE	BOTH		RIGHT EYE	LEFT EYE	BOTH		RIGHT EYE	LEFT EYE	BOTH
Blurry spot in vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blurry vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bump on eyelid(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burning sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Crossed eye (s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetic eye exam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eye pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Distorted vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Double vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Droopy lids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dry eye(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eye lashes turning in	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Flashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Floaters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Foreign body sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glare	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Glasses re-check	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma evaluation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Itchy eyelids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Itchy eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain in eye(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Red eye(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Watery eye(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wish to be free from glasses/contacts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other:							

REVIEW OF SYSTEMS				CURRENT SYMPTOMS			
Do you currently have any of the following problems?	Never	Occasional	Frequent	Are you <i>currently</i> having any of the following eye problems?	YES	NO	TYPE/OTHER
GENERAL				Do you wear glasses?	<input type="checkbox"/>	<input type="checkbox"/>	
Fatigue, Irritable, Hot/cold, Chills, Sweats, Weight Gain or Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear contacts?	<input type="checkbox"/>	<input type="checkbox"/>	
HEAD/NEUROLOGIC				Do you have blurred vision?	<input type="checkbox"/>	<input type="checkbox"/>	
Headaches, Head injury, Neck injury, Dizziness, Convulsions, Slurred speech, Memory loss, Concentration problems, Weakness, Strokes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have difficulty driving due to vision?	<input type="checkbox"/>	<input type="checkbox"/>	
BONES/JOINTS				Do you have problems with night vision?	<input type="checkbox"/>	<input type="checkbox"/>	
Arthritis, Bursitis, Tendonitis, Cramps/spasms, Swollen joints, Pain between shoulders, Back pain, Dislocations, Gout, Stiffness, Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Glare/light sensitivity?	<input type="checkbox"/>	<input type="checkbox"/>	
KIDNEYS/BLADDER				Dryness?	<input type="checkbox"/>	<input type="checkbox"/>	
Blood in urine, Frequent urination, Painful urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tearing?	<input type="checkbox"/>	<input type="checkbox"/>	
EARS				Itching/Allergies	<input type="checkbox"/>	<input type="checkbox"/>	
Ringling/buzzing, Drainage, Motion sickness, Loss of hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mucous Discharge?	<input type="checkbox"/>	<input type="checkbox"/>	
FACE/THROAT				Redness?	<input type="checkbox"/>	<input type="checkbox"/>	
Sinusitis, Frequent colds, Problems swallowing, Pain in chewing, Pain in your jaw(s), Dentures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Foreign body sensation?	<input type="checkbox"/>	<input type="checkbox"/>	
LUNGS				Infection on eye or lid?	<input type="checkbox"/>	<input type="checkbox"/>	
Tuberculosis, Asthma, Pneumonia, Shortness of breath, Chronic cough, Wheezing, Blood clots	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eye pain / soreness?	<input type="checkbox"/>	<input type="checkbox"/>	
HEART				Double vision?	<input type="checkbox"/>	<input type="checkbox"/>	
Palpitations, Rapid heart rate, Chest pain, High blood pressure, Shortness of breath, Leg cramps (walking), Swollen feet/ankles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Floaters / flashes of light?	<input type="checkbox"/>	<input type="checkbox"/>	
CIRCULATION				Crossed eye?	<input type="checkbox"/>	<input type="checkbox"/>	
Varicose veins, Blood clots, Easy bleeding, Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Drooping eyelids?	<input type="checkbox"/>	<input type="checkbox"/>	
SKIN					<input type="checkbox"/>	<input type="checkbox"/>	
Pain, Itching, Dryness, Eczema, Rashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you interested in learning if you are a candidate for LASIK?	<input type="checkbox"/>	<input type="checkbox"/>	
GASTROINTESTINAL							
Regurgitation, Ulcers, Abdominal pain, Nausea, Vomiting, Diarrhea (frequent), Constipation, Blood in stool, Hepatitis, Pancreatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
WOMAN ONLY							
Painful menstruation, Hot flashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Are you pregnant? <input type="checkbox"/> yes <input type="checkbox"/> no							

PAST / OTHER MEDICAL HISTORY						
PAST MEDICAL HISTORY <i>(Current medical problems such as diabetes, hypertension or high cholesterol)</i>	Diagnosis		Treating Physician			
EYE HISTORY <i>(circle those you have been treated for)</i>	Cataracts	Iritis/Uveitis	Retinal Tear	Glaucoma		
	Dry Eye	Retinal Detachment	Amblyopia (lazy eye)	Macular Degeneration		
	Double Vision	Strabismus (crossed eye)	Floaters	Macular Hole		
	Blepharitis (eyelid inflamed)	Eye Allergies	Eye Injury explain: _____			
ALLERGIES <i>(medications or environmental)</i>						
MEDICATION AND SUPPLEMENTS <i>(please all medications you take—even if only occasionally)</i>	Medication	Dose	How Often	When Started	Why?	
EYE SURGICAL HISTORY	Surgery		Date	Surgeon		
SURGICAL HISTORY	Surgery		Date	Surgeon		
FAMILY HISTORY	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No		Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Macular Degeneration	<input type="checkbox"/> Yes <input type="checkbox"/> No		Retina Detached	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Lazy Cross Eye	<input type="checkbox"/> Yes <input type="checkbox"/> No		Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No		Rheumatoid Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No		Degenerative Disc Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No		Alcoholism / Drug Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	
SOCIAL HISTORY	Occupation?		_____			
	Do you smoke?	<input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, how much?	_____	
	Do you drink alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, how much/often?	_____	
	Do you use recreational drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, how much/often?	_____	
ACTIVITY LEVEL	Recreational activity level?		_____			
	Goals for treatment?		_____			



PATIENT RECORD OF DISCLOSURES / COORDINATION OF CARE / MEDICATION CONSENT

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I WISH TO BE CONTACTED IN THE FOLLOWING MATTER (CHECK ALL THAT APPLY):

- Home telephone, Written communication, OK to leave a detailed message, Leave message with call back number ONLY, OK to mail to home address, OK to fax to this number, Work telephone, OK to leave info with specified people, OK to leave a detailed message at work, OK to mail to my work address, Leave message with call back number ONLY

COORDINATION OF CARE DISCLOSURE

OTHER HEALTH CARE PROVIDERS

PRIMARY CARE Practice name, Address, City, Telephone, Physician/Provider Name, Specialty, State, Zip, Fax

SPECIALTY Practice name, Address, City, Telephone, Physician/Provider Name, Specialty, State, Zip, Fax

CONSENT TO OBTAIN PATIENT MEDICATION HISTORY

A patient's medication history is a list of prescription medications that our practice providers or other providers have prescribed for you. Different courses including pharmacies, health insurers, and other physicians contribute to the collection of this history.

The collected information is to be stored in our practice's electronic medical records system (EMR) and will become a part of your personal medical record. Medication history is very important in helping healthcare providers treat your symptoms and/or illness properly and helping to avoid potentially dangerous drug interactions.

MY PHARMACY INFORMATION

Pharmacy Name, Address, Telephone #, City, State, Zip

I give my permission to my healthcare provider, and their clinical staff to obtain my medication history from my pharmacy, my health plans, and my healthcare providers

Printed Name:

Patient Signature:

Date:



REFERRAL INFORMATION

Patient Name: _____

Today's

Date:

Tell us who referred you to our office?

- Internet - Internet Search Engine (i.e., Google, Yahoo!, etc.) _____
- Website - Website name _____
- Social Media – which media (i.e., Facebook, Twitter, Instagram) _____
- Employer
- Physician: _____
- Emergency room
- Friend / Relative
- Self
- Magazine article
- Other: _____



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CATARACT & LASER
REFRACTION CONSENT

What is a Refraction?

Refraction is a measurement taken by our doctor to determine whether a patient has nearsightedness (myopia), farsightedness (hyperopia), or astigmatism. Based on the results of the refraction, our doctor decides whether or not to prescribe glasses. A refraction can be accurately performed on a patient of any age, with or without his or her input. For the majority of patients, refraction is a critical component of an eye examination.

Will My Insurance Pay for a Refraction?

Even though this is a vital test in the care of your eyes, **the refraction is a non-covered benefit with most insurance plans.** Unfortunately, they do not differentiate between “medical refractions” and refractions performed for the purpose of providing glasses or contact lenses.

There is a fee of \$40.00 for this test. You will be asked to pay at the time of your visit. This fee will be charged to you approximately one time per year. As a courtesy to our patients, we submit this charge to Medicare and/or the insurance companies. If your insurance plan should cover this benefit, we will promptly refund you any balance due back to you.

Consent to Treat: I voluntarily consent to such care and treatment as prescribed by the physicians as is necessary in his or her judgement.

Release of Information Assignment of Benefits: I authorize use of this form on all of my insurance submissions and authorize release of information needed to process a claim to any of my insurance companies. I permit a copy of this to be used in place of the original. I authorize the provider to act as my agent in helping me obtain payment from my insurance companies. I understand the provider does not accept responsibility for collecting my insurance claims or for negotiating a settlement in disputed claims. I assign any rights and claims for reimbursement of expenses allowable under my insurance plan and authorize payment directly to the provider for services rendered. I understand I will receive a monthly statement for any balance due by me. I hereby authorize Colorado Cataract & Laser LLC its agents, employees and affiliates to have access to my complete medical records for the purpose of billing and management functions as they deem necessary.

Advance Beneficiary Notice of Noncoverage (ABN)

If you are a Medicare patient, please note that Medicare does not pay for everything, even some care that you or your health care provider has good reason to think you need. We expect Medicare may not pay for a refraction.

Code:	92015 Refraction	Reason Medicare May not Pay:	Non-covered Service	Estimated Cost:	\$40.00
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- I want the Refraction and I ACCEPT** the refraction fee of \$40.00 if my insurance and/or Medicare does not cover the fee. I understand that this procedure was done to determine my visual status or to review a new prescription. If I have Medicare, I understand that if Medicare doesn’t pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, I will refund any payments I made to CCL, less co-pays or deductibles.
- (Medicare ONLY) I want the Refraction, but do not bill Medicare.** I will pay now as I am responsible for payment. I cannot appeal if Medicare is not billed.
- I DECLINE** the refraction procedure and do not wish to be responsible for payment. I understand with this choice I am not responsible for payment, and I cannot appeal to see if my insurance and/or Medicare would pay.

Signing below means that you have received and understand this notice. You also receive a copy.

Patient Signature: _____ Dated: _____

The privacy rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048).



PATIENT PORTAL AUTHORIZATION FORM

Colorado Cataract & Laser LLC ("CCL") offers secure viewing and communications as a service to patients and their personal representative ("patient") who wish to view parts of their records and communicate with our staff and physicians. Secure messaging can be available communications tool but has certain risks. In order to manage these risks, we need to impose some conditions of participation. This form is intended to show that you have been informed of these risks and the conditions of participation, and that you accept the risks and agree to the conditions of participation.

How the Secure Patient Portal Works

A secure web portal is a type of webpage that uses encryption to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password or pass-phrase to log in to the portal site. Because the connection channel between your computers and the website uses secure sockets layer technology you can read or view information on your computer, but it is still encrypted in transmission between the website and computer. The patient portal is provided as a courtesy to CCL's valued patients. CCL is focused on providing the highest level of service and health care. However, if abuse or negligent use of the Patient Portal persists, CCL reserves the right at its own discretion to terminate the patient portal offering, suspend user access, or modify services offered through the patient portal.

Protecting Private Health Information and Risks

This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. No transmission system is perfect and we will do our best to maintain electronic security. However, keeping messages secure depends on two additional factors: 1) the secure message must reach the correct email address, and 2) only the correct individual (or someone authorized by the individual) must be able to have access to the message. Only you can make sure these two factors are present. It is imperative that our practice has the correct email address and stays informed of any changes to that email address. We also recommend that users consider using a personal email address, rather than an email address through an employer. In the interest of keeping the information confidential.

Users also need to keep track of who has access to their email accounts that only the user, or someone the user authorizes, can see the messages received from CCL. The user is responsible for ensuring that unauthorized individuals do not learn the password. If it appears that someone has learned the password, the user should promptly go to the website and change it. All medical communications carry some level of risk. While the likelihood of risks associated with the use of online communications, particularly in a secure environment, is substantially reduced, the risks are nonetheless real and very important to understand. It is very important that each user consider these risks each time there is communication with CCL, and the user should communicate in such a fashion as to mitigate the potential for any of these risks.

Types of Online Communication/Messaging

Online communications should never be used for emergency communications or urgent requests. If there is an emergency or an urgent request, the user should contact the CCL physician by telephone. If there is information that the user does not want transmitted via online communication, he or she should inform CCL.

Patient Acknowledgement and Agreement

Access to this secure patient portal is an optional service, and CCL may suspend or terminate it at any time for any reason. Further, CCL may amend its policies and procedures related thereto. I will be informed of any material changes and can opt-out at that time. I understand that my access to this portal will not affect the current level of care provided by CCL. I acknowledge that I have read and fully understand this Consent Form. I have been given risks and benefits of the Patient Portal and agree that I understand the risks associated with online communications between a physician and myself, and I consent to the conditions outlined in this form. In addition, I agree to adhere to the policies set forth in this form, as well as any other instructions or guidelines that my physician may impose for online communications. It is my responsibility to notify CCL if there is a change in my email address or I feel that my secure password has been breached. I agree not to hold CCL or any of its staff liable for network infractions beyond its control.

Your Secure Email: _____ *(This will be your User Name for the Patient Portal)*



Print Name: _____

DOB: _____

Patient Signature: _____

Date: _____

PATIENT PORTAL LOGIN INFORMATION

1. Once your account is created, you will receive a confirmation email from CCL.
2. This email will contain a link to activate your account.
3. You will then be asked to verify your identity by providing your **date of birth** and **last name**.
4. After you verify your identify you will be asked to create a new password
5. After you create your password, you can log into the Portal at any time by visiting us at <https://www.coloradocataractandlaser.com/>
6. Click the PATIENT INFORMATION tab
7. Select PATIENT PORTAL
8. From the PATIENT PORTAL, you will be able o view your healthcare information as well as communicate with the practice through a secure online messaging system.

From the PATIENT PORTAL, you will be able to view your healthcare information as well as communicate with the practice through a secure online messaging system.

PLEASE NOTE: THE PORTAL IS FOR NON-URGENT COMMUNICATION ONLY