COLORADO
CATARACT LASER & VISION

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

- Current list of all medicatons and dosages. 274 7
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- Bring your insurance cards. C 34 ' # 3 ' 4
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COLORADO
CATARACT & LASER

Jennifer Grin, MD, FACS
Jacob J. Koczman, MD
Alexia Bounkhong, OD

PATIENT DEMOGRAPHIC FORM

Today's Date: _____

Patient Name: _____ Date of Birth: _____ Age: _____ Sex: ☐ M ☐ F

Address: _____ Marital Status: ☐ S ☐ M ☐ D ☐ W ☐ O

City: _____ State: _____ Zip: _____ Cell Ph#: _____ Work Ph#: _____

Email: _____ Employer Name: _____

PERSON WHO SIGNS CONSENT AND IS RESPONSIBLE FOR BILL ☐ SELF

Insured (Responsible) Party Name: _____ Relationship to Patient: _____

_____

Address: _____ Date of Birth: _____

City: _____ State: _____ Zip: _____

Home Ph#: _____ Work Ph#: _____

INSURANCE INFORMATION

Primary Insurance: _____ Phone: _____

Group #: _____ Subscriber/SS#: _____ Relation to insured: ☐ Self ☐ Spouse ☐ Child

Do you have Secondary Insurance? ☐ Y ☐ N

Secondary Insurance: _____ Phone: _____

Group #: _____ Subscriber/SS#: _____ Relation to insured: ☐ Self ☐ Spouse ☐ Child

I hereby assign payment directly to Colorado Cataract, Laser and Vision, 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 and Vision *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 and Vision. I also understand that Colorado Cataract, Laser and Vision 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

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FINANCIAL POLICY

Welcome to the Colorado Cataract Laser & Vision LLC. 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.

EYEGLASS PRESCRIPTION (REFRACTION): I understand that refraction is 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 CCLVC. **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 CCLVC 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. 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 CCLVC 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 or 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. 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 CCLV 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 & Vision 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: _____

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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
Blurred Vision	☐	☐
Vision Loss	☐	☐
Glare	☐	☐
Double Vision	☐	☐
Cataract Exam	☐	☐
Glasses Exam	☐	☐
LASIK Exam	☐	☐
Contact Lens Exam	☐	☐

	RIGHT EYE	LEFT EYE
Eye Pain	☐	☐
Red Eye	☐	☐
Itching	☐	☐
Dry Eye	☐	☐
Tearing	☐	☐
Discharge	☐	☐
Eyelid lesion	☐	☐

	RIGHT EYE	LEFT EYE
Glaucoma Exam	☐	☐
Diabetic Exam	☐	☐
Flashes	☐	☐
Floaters	☐	☐
Droopy Eyelids	☐	☐
Other:	☐	☐

REVIEW OF SYSTEMS

Do you currently have any of the following problems?	Yes	No			Yes	No	
GENERAL				**HEART**			
Fatigue, Irritable, Hot/cold, Chills, Sweats, Weight Gain or Loss	☐	☐		Palpitations, Rapid heart rate, Chest pain, High blood pressure, Shortness of breath, Leg cramps (walking), Swollen ankles	☐	☐	
HEAD/NEUROLOGIC				**CIRCULATION**			
Headaches, Head injury, Dizziness, Convulsions, Slurred speech, Memory loss, Concentration problems, Weakness, Strokes	☐	☐		Varicose veins, Blood clots, Easy bleeding, Anemia	☐	☐	
BONES/JOINTS				**SKIN**			
Arthritis, Tendonitis, Cramps/spasms, Swollen joints, Pain between shoulders, Back pain, Gout, Osteoporosis	☐	☐		Pain, Itching, Dryness, Eczema, Rashes	☐	☐	
EARS				**GASTROINTESTINAL**			
Ringing/buzzing, Motion sickness, Loss of hearing	☐	☐		Regurgitation, Ulcers, Abdominal pain, Nausea, Vomiting, Diarrhea, Constipation, Hepatitis, Pancreatitis	☐	☐	
FACE/THROAT				**KIDNEYS/BLADDER**			
Sinusitis, Problems swallowing, Pain in chewing, Pain in your jaw(s), Dentures	☐	☐		Blood in urine, Frequent urination, Painful urination	☐	☐	
LUNGS				**WOMAN ONLY**			
Tuberculosis, Asthma, Pneumonia, Shortness of breath, Chronic cough, Wheezing, Blood clots	☐	☐		Painful menstruation, Hot flashes	☐	☐	
				Are you pregnant? ☐yes ☐no			

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PAST / OTHER MEDICAL HISTORY

PAST MEDICAL HISTORY
(Current medical problems such as diabetes, hypertension or high cholesterol)

Diagnosis	Treating Physician

EYE HISTORY
(circle those you have been treated for)

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
(medications/environmental)

MEDICATION AND SUPPLEMENTS
(please all medications you take—even if only occasionally)

Medication	Dose	How Often	When Started	Why?

EYE SURGICAL HISTORY

Surgery	Date	Surgeon

SURGICAL HISTORY

Surgery	Date	Surgeon

FAMILY HISTORY

Glaucoma	☐ Yes ☐ No	Cataracts	☐ Yes ☐ No
Macular Degeneration	☐ Yes ☐ No	Retina Detached	☐ Yes ☐ No
Lazy Cross Eye	☐ Yes ☐ No	Disability	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Rheumatoid Arthritis	☐ Yes ☐ No
Heart Disease	☐ Yes ☐ No	Degenerative Disc Disease	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Alcoholism / Drug Abuse	☐ Yes ☐ No

SOCIAL HISTORY

Occupation?	_____		
Do you smoke?	☐ Yes ☐ No	If yes, how much?	_____
Do you drink alcohol?	☐ Yes ☐ No	If yes, how much/often?	_____
Do you use recreational drugs?	☐ Yes ☐ No	If yes, how much/often?	_____

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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_____

☐ OK to leave a detailed message
☐ Leave message with call back number ONLY

☐ Work telephone_____

☐ OK to leave a detailed message at work
☐ OK to mail to my work address

☐ Written communication

☐ OK to mail to home address
☐ OK to fax to this number_____

☐ OK to leave info with specified people (i.e., attorney, spouse, friend)
_____

☐ Leave message with call back number ONLY

COORDINATION OF CARE DISCLOSURE

OTHER HEALTH CARE PROVIDERS

PRIMARY CARE Practice name: _____ **Physician/Provider Name:** _____

Address:_____ Specialty:_____

City:_____ State:_____ Zip:_____

Telephone:_____ Fax: _____

SPECIALTY Practice name: _____ **Physician/Provider Name:** _____

Address:_____ Specialty:_____

City:_____ State:_____ Zip:_____

Telephone:_____ 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. It is very important that you and your provider discuss your recorded medication history, to insure it is 100% accurate. Some pharmacies do not make all drug history information available, and you may not include over-the-counter (OTC) medications purchases without health insurance. Other supplements and herbal remedies that patients may take may not be included in this list.

MY PHARMACY INFORMATION

Pharmacy Name: _____ Telephone #: _____

Address: _____ 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: _____

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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

Jennifer Grin, MD, FACS
Jacob J. Koczman, MD
Alexia Bounkhong, OD

REFRACTION CONSENT

What is a Refraction?

- **We always check your vision but the refraction is a test to determine your best possible vision and whether glasses/contacts are needed to achieve this.**
- **A series of lenses are presented to determine which prescription provides the best vision. • This will determine if decreased vision is associated with a medical condition or the need for an updated glasses prescription**
- **It is needed to determine eligibility for cataract surgery**

Will My Insurance Pay for a Refraction?

Though this is a vital test in your care, ***the refraction is a non-covered benefit with most insurance plans***. They do not differentiate between refractions performed for the purpose of providing glasses or contact lenses and medical reasons.

There is a fee of $50.00 for this test if it is not covered by your insurance. You will be asked to pay at the time of your visit. If your insurance plan should cover this benefit, we will promptly refund you any balance due back to you.

☐ **I ACCEPT** the refraction test and fee of $50.00 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 determine a new prescription.

☐ **I Decline** the refraction test. I understand that I will not be able to receive a glasses prescription.

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

Patient Signature: _____ Dated: _____

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PATIENT PORTAL AUTHORIZATION FORM

Colorado Cataract Laser & Vision LLC ("CCLV") 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 CCLV's valued patients. CCLV is focused on providing the highest level of service and health care. However, if abuse or negligent use of the Patient Portal persists, CCLV 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 CCLV. 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 CCLV, 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 CCLV physician by telephone. If there is information that the user does not want transmitted via online communication, he or she should inform CCLV.

Patient Acknowledgement and Agreement

Access to this secure patient portal is an optional service, and CCLV may suspend or terminate it at any time for any reason. Further, CCLV 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 CCLV. 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 CCLV if there is a change in my email address or I feel that my secure password has been breached. I agree not to hold CCLV 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)*

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Print Name: _____ DOB: _____

Patient Signature: _____ Date: _____

PATIENT PORTAL LOGIN INFORMATION

1. Once your account is created, you will receive a confirmation email from CCLV.
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 identity, you will be asked to create a new password
5. After you create your password, you can log into the Patient 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 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