COLORADO
CATARACT LASER & VISION

Welcome to Colorado Cataract Laser & Vision!

Welcome to Colorado Cataract Laser & Vision (CCLV). 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 attached below. 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, phone message or email 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. CCLV 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 & Vision Center Clinic Staff

COLORADO
CATARACT & LASER

Jennifer Grin, MD, FACS
Jacob J. Koczman, MD
Thomas Wilson, 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 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.

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. 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.

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 bell 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 FEES

Visits: If you are unable to attend your scheduled appointment, 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.

Surgeries: The date and time of your procedure depends on a great number of factors including your schedule, the surgeon's schedule, and the Operating Room availability. Therefore, we may not be able to accommodate all preferences. We request that you choose your surgical date/time with the utmost care. Our policy for changes and cancellations is as follows: if you cancel or reschedule your surgery with less than 48 hours (2 business days) notice or fail to show, the fee is $200. No fee will be assessed if cancellation is the result of medical necessity.

I have read and understand the *Financial Policy,* and that the practice requires my signature. 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: _____

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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

☐ Written communication

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

☐ Work telephone_____

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

☐ 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: _____

COLORADO
CATARACT LASER & VISION

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 & VISION

INFORMATION AND CONSENT FOR REFRACTION

The purpose of this form is to help you make an informed choice about whether you want to receive these services. **The charge for refractions is $50.00 and is due at the time of service with any co-pays**. We will file this amount with the appropriate insurance plan, and you will be reimbursed if it is covered by them.

What is a Refraction?

- A refraction is how we determine the best possible visual acuity and function of your eye, which is essential medical information for us to have as we assess your eyes and look for problems.
- A refraction is the procedure used to determine your need for lenses to correct your refractive error also referred to as your refraction or your eyeglass prescription.
- We always check your vision, but a refraction will be done if you request an eyeglass prescription or want to know if you need a new eyeglass prescription.

Why do I have to pay for it?

- CMS, the department of the federal government that controls Medicare has decided that refractions are not a payable part of an eye exam.
- CMS, directly under the control of the US Congress, has determined this is a "non-covered" service. That means you must pay for that portion of the eye exam.
- Further, CMS has declared that if we don't charge you extra of this service, we could receive various forms of punishment.

What does it do?

- This instrument determines your need for lenses to correct your refractive error, also referred to as your refraction or your eyeglass prescription.
- This is the part of the exam where the doctor or other staff member flips various lenses inside the phoropter and asks questions like "better 1 or better 2?" We keep asking these questions until we have helped you achieve the best possible vision.

Is this new?

- Refraction (CPT code 95015) has been a "non-covered" service since Medicare was created in 1965.
- Since about 2007, Medicare has been enforcing the policy of requiring eye doctors to charge separately for refractions.
- As many private insurance carriers adopt the policies of the deferral government, many of our contracts with private insurance carriers requires us to collect the money from you, as well.

Advance Beneficiary Notice of Noncoverage (ABN)

Code: **92015 Refraction**	Reason Medicare May not Pay: **Non-covered Service**	Estimated Cost: **$50.00**

☐ **YES:** I choose to receive the Refraction test

☐ **NO:** I choose not to receive the Refraction test

Signing below means that you have received and understand this notice.

Patient Signature: _____ Dated: _____

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).