INSIGHT VISION GROUP

☐ **New Patient**
☐ **Established Patient**

_____ _____
Patient Name DOB

_____
Preferred Name

Preferred Pronoun: ☐ She/her ☐ He /him ☐ They/their ☐ Prefer no pronoun ☐ No preference

_____ _____ _____
Billing Address City Zip Code

_____ _____ _____
Cell Phone Home Phone Work Phone

_____ May we contact you via email|text? YES NO
Email Address

_____ _____ _____
Emergency Contact Emergency Contact Phone Relationship to Patient

_____ _____
Name of Insurance Policy Holder (or self) DOB of Insurance Policy Holder

_____ _____ _____
Preferred Pharmacy & Cross Street Optometrist Name Primary Care Physician Name

Who may we thank for referring you? _____

What is the reason for today's visit? _____

Do you have any allergies to medications or substances? _____

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, others pay a percentage of charge, and some do not pay for some charges. It is the patient's responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by their insurance.

I directly assign all medical/surgical benefits related to my visits here to Insight Vision Group and understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be valid as the original.

Sign Here:_____Date:_____

4430 Arapahoe Avenue, Suite 155 Boulder, CO 80303 Phone: 303-402-1000 | Fax: 303-593-2199
1332 Vivian Street Longmont, CO 80501 Phone: 303-402-1000 | Fax: 303-593-2199

INSIGHT VISION GROUP

FINANCIAL POLICY

The following is a statement of our financial policy, which we require you read and sign prior to any treatment. Please let us know if you have any questions.

If you are seeing the doctor for a medical condition we will bill your insurance. If you are required to have a referral from your primary physician, it is your responsibility to obtain this referral prior to your visit. If you do not obtain the referral, you may be responsible for all charges. If you require assistance in this matter, our office may be able to help. It is your responsibility to know the benefits and coverage requirements of your insurance policy.

If you are seeing the doctor for routine vision examination, full payment is due at the time of visit. If you have coverage for routine care we will bill your insurance provided that all requirements are met, i.e. doctor participation and interval of vision benefit. If a preauthorization is required, it is your responsibility to obtain this prior to your visit. It is your responsibility to know your insurance policy.

Please note that most insurance companies, including Medicare, do not cover refractions. This procedure may be required at all visits. If your insurance does not cover this procedure, you will be responsible for the charge. Ultrasounds and High Resolution Ultrasounds are sometimes not covered by insurance companies. If this test is required for you and your insurance does not cover the procedure, you will be responsible for the charge.

All copays are due at the time of the visit. If there is any balance due from you after your claim is processed such as deductible or coinsurance, we will send a statement to your home address. Balance is due upon receipt of the statement. If payment cannot be made in full within 30 days, please contact our office for possible payment arrangement. If you are uninsured, full payment is due at time of service.

Patient balances that have not been paid in full by 90 days from the date of service will be forwarded to a collection agency. The ability to schedule follow up appointments will be suspended until overdue balances are paid in full.

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any private insurance company's arbitrary determination of usual and customary.

I have read, understand and agree to this financial policy.

Signature:_____ Date:_____

INSIGHT VISION GROUP

NOTICE OF PRIVACY PRACTICES

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

- At our office, we have always kept your health information secure and confidential. Privacy laws require us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.
- The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.
- We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.
- We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.
- We may share your medical information with our business associates such as a billing service. We may have a written contract with each business associate that requires them to protect your privacy.
- We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your appointments. If you are not at home, we may leave this information on your voicemail or with the person who answers the telephone.
- In an emergency, we may disclose your health information to a family member or another person responsible for your care.
- We may release some or all of your health information when required by law.
- If this practice is sold, your information will become the property of the new owner.
- Except as described above, this practice will not use or disclose your health information beyond the normal uses.
- As we will need to contact you, we will use whatever address or telephone number you prefer.
- You have the right to transfer copies of your health information to another practice. We will mail your files to you.
- You have the right to see and receive a copy of your health information, with a few exceptions. Give us your written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for copies.
- You have the right to request amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change we will not remove or alter earlier documents, but will add new information.
- You have a right to receive a copy of this notice. If you would like a copy, please ask the front desk staff.
- If we change any of the details of this notice, we will notify you of the changes in writing.
- You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S.W. Room 509F, Washington, DC 20201. You will not be retaliated against for filing a complaint.
- However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy Officer at 4430 Arapahoe Avenue Suite 155 Boulder, CO 80303.
- This notice goes into effect as of April 14, 2003

Acknowledgement: I have read and understood this office's Notice of Privacy Practices.

Signature:_____ Date:_____

INSIGHT VISION GROUP

HEALTH HISTORY

Name _____ **Age** _____ **Date**_____

Chief Problem _____

Other Medical Providers _____

Known Eye Problems:	**R**	**L**	**Onset**	**Previous Eye Surgery:**
□ Cataracts	___	___	_____	Right Eye_____
□ Injury	___	___	_____	_____
□ Farsighted/Nearsighted	___	___	_____	_____
□ Lazy Eye	___	___	_____	
□ Retinal Disease	___	___	_____	Left Eye_____
□ Corneal Disease	___	___	_____	_____
□ Glaucoma	___	___	_____	_____

Present Eye Medications:

Name (circle)	Year Started	Which Eye(s)	How Often Per Day	Used Before?	Allergy to Med?
Alphagan (P)/Brimonidine	_____	R L Both	1 2 3 4	Y N	_____
Azopt	_____	R L Both	1 2 3 4	Y N	_____
Betagan (levobunolol)	_____	R L Both	1 2 3 4	Y N	_____
Betaxolol or Carteolol	_____	R L Both	1 2 3 4	Y N	_____
Combigan	_____	R L Both	1 2 3 4	Y N	_____
Cosopt	_____	R L Both	1 2 3 4	Y N	_____
Diamox or Neptazane Pill	_____	R L Both	1 2 3 4	Y N	_____
Dipivefrin (Propine)	_____	R L Both	1 2 3 4	Y N	_____
Doxycycline Pill	_____	R L Both	1 2 3 4	Y N	_____
Lumigan	_____	R L Both	1 2 3 4	Y N	_____
Ocupress/OptiPranolol	_____	R L Both	1 2 3 4	Y N	_____
Ointment:_____	_____	R L Both	1 2 3 4	Y N	_____
Pilocarpine (GEL?)	_____	R L Both	1 2 3 4	Y N	_____
Restasis	_____	R L Both	1 2 3 4	Y N	_____
Steroid Eye Drop	_____	R L Both	1 2 3 4	Y N	_____
Timoptic/Timolol	_____	R L Both	1 2 3 4	Y N	_____
Travatan	_____	R L Both	1 2 3 4	Y N	_____
Xalatan	_____	R L Both	1 2 3 4	Y N	_____
Vigamox/Zymar	_____	R L Both	1 2 3 4	Y N	_____
Other:_____	_____	R L Both	1 2 3 4	Y N	_____
Other:_____	_____	R L Both	1 2 3 4	Y N	_____

Please List All Allergies_____

_____

_____

Active Medical Problems:

□ Asthma
□ Diabetes
□ High Blood Pressure
□ Heart Disease
□ Stroke
□ Migraines
□ TB
□ Hepatitis
□ HIV
□ Seizures
□ Blood Disorder
□ Psychiatric Condition
□ Nervous Condition
□ Temporal Arteritis
□ Arthritis
□ Skin Disorder

Additional History:

Do you smoke?
Y N
Do you drink alcohol?
Y N
Any occupational hazard exposure?
Y N
Do you drive?
Y N
Do you have visual problems driving?
Y N
Do you have night vision problems?
Y N
Have you had a blood transfusion?
Y N

Family History:

(please note family member
F=father, M=mother, S=sister
B=brother, C=child, A=aunt, U=uncle
GP=grandparent, O=other)

□ Glaucoma _____
□ Cataracts _____
□ Corneal Disease _____
□ Retinal Disease _____
□ Diabetes _____
□ Heart _____
□ Stroke _____
□ Cancer _____
□ Other: _____
_____

Please List Current General Medications_____

_____

_____

_____

Other Medical and Surgical History: (please write out any problems and year it occurred)

_____

_____

_____

_____

System Review: (circle symptoms that apply to you)

General: fatigue weight loss fevers chills tired

Skin: rash blisters dry patches spots

Nose, Ear, Throat: nasal drip sinus infections poor hearing sore throat dry mouth missing teeth

Heart: palpitations chest pain short of breath sleep with head elevated irregular heartbeat

Lungs: cough wheezing gasping pneumonia

Abdomen: stomach pain diarrhea bleeding pain tenderness

Muscles: weak lifting arms or climbing steps no strength

Bones: osteoporosis joint pain easy fractures

Genito-urinary: kidney stones burning with urination incontinence pregnant

Nervous system: tremor imbalance