Patient Registration

Please verify the following information, make necessary changes and supply any missing information.

Patient Information

				Date of Birth	Today's Date
Patient Name (First, Middle, Last)	Suffix (Jr.,Sr.)	Salutation (Mr.,Ms.)	Preferred Name	Sex	Age
Address (Street, City, State, Zip)					
Home Phone	Cell Phone	Email Address			
Primary Language	Special Needs (Wheelchair, Translator Hearing Impaired)	Social Security #	Primary Eye Doctor		
Primary Care Physician	Primary Care Physician Phone	Other Specialist Eye Doctors	Other Specialist Phone		

Parent/Legal Guardian (If patient is under 18)/Account Responsible:

		Patient's Relationship to the Responsible Party (Self, Spouse, Child)		
Responsible Party's Name (Salutation, First, Middle, Last)	Date of Birth	Home Phone	Cell Phone	Work Phone / Ext
Address (Street, City, State, ZIP)		Email Address	Social Security #	Gender

Primary Insurance

Insured's Name	Insurance Company Name

Secondary Insurance

Insured's Name	Insurance Company Name

Contacts

Name / Relationship	Emergency Contact	Release of Medical Information	Phone

Signature: _____ **Date:** _____

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. A new law requires 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 home, we may leave this information on your answering machine 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 without your prior written authorization.

You may request in writing that we do not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

As we will need to contact you from time to time, 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 receptionist.

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 11960 Lioness Way, #190, Parker, CO 80134.

This notice goes into effect as of April 14, 2003.

Acknowledgement: I have received a copy of this office's Notice of Privacy Practices. **Date**_____

Signed_____ Print Name_____

If signing as a parent or guardian, please note the name of the patient_____

Financial Policies Statement

General Policy

Our policy is to bill insurance claims as a courtesy for our patients. In order to bill your insurance claims correctly we need the following:

- **A copy of your most current insurance card**
- **Social Security number of both the patient and the responsible party.**
- **Your current address, which must match the address on file with your insurance company**

Patient Responsibility

Any fees collected at the time of service and any quotes regarding such fees are **estimated** based on the information available to us at the time of service.

If you are seeing the doctor for a medical condition, we will bill your medical insurance. If you are required to have a referral from your primary care physician, it is **your responsibility to obtain this 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.**

Please note that most insurance companies, including **Medicare, do not cover refractions.** This procedure may be required at all your 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.

If you are seeing the doctor for a **routine vision examination**, full payment is due at the time of service. If you have coverage for routine care we will bill your routine vision insurance. Please note that additional services such as contact lens exams are not typically covered by insurance companies. Therefore, you may be responsible for a fee. **It is your responsibility to know what your insurance policy covers. If a preauthorization is required, it is your responsibility to obtain this prior to your visit.**

All **copays, previous balances** and **non-covered services** are due **at the time of service**. If there is any balance due from you after your insurance company has processed your medical claim, such as a **deductible** or **co-insurance**, we will send a statement to your home address. **Balances are due upon receipt of the statement.** If payment cannot be made in full within 30 days of receipt, please contact our office to arrange a payment plan.

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.

Glasses are made specifically for you and your prescription, for that reason after the order has been started, they cannot be returned for a refund. We will do our best to ensure the frames fit properly and the lenses are made to our high standards.

I have read, understand and agree to this Financial Policy.

Patient Name_____Signature_____ Date_____

Acknowledgement of Receipt

I acknowledge that I received a copy of Insight Vision Group and Associated Eye Care Services LLC's Notice of Privacy Practices.

Patient Name_____Signature_____ Date_____

11960 Lioness Way Suite 190
Parker, CO 80134
Phone: 303-794-1111
Fax: 303-347-1341

INSIGHT VISION GROUP

Authorization for Release and Request for Medical Information

I hereby authorize and request the protected health information of:

Patient Name: _____ DOB: ____/____/_____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____ - _____ Today's Date ___/___/_____

Reason for this authorization: _____

Check All Desired Items, Current To 7 Years, for the following date range: ___ /___ /_____ to ___ /___ /_____

- ☐ Eye Glass Prescription
- ☐ Contacts Prescription
- ☐ Exam Notes and Diagnosis
- ☐ Surgical (includes operative report)
- ☐ Diagnostic Test Results (retinal, corneal, visual fields, etc)

Requests take 30 days to process. If you will need your records before the 30-day limit, please inform us of the deadline here: ___/___/2021

Release FROM	**Release TO**
Name: _____	**Name:** _____
Address: _____	**Address:** _____
City: _____ **State:** _____ **Zip:** _____	**City:** _____ **State:** _____ **Zip:** _____
Phone: (_____) _____ - _____	**Phone: (_____) _____ - _____**
Fax: (_____) _____ - _____	**Fax: (_____) _____ - _____**

I may refuse to sign this authorization and my refusal will have no impact on receiving treatment. I can inspect or copy any information disclosed under this agreement. I have voluntarily signed this document. I can revoke this authorization at any time and the revocation must be in writing. I understand that the revocation will not apply to information that has already been released. I will receive a copy of this authorization if requested. The federal privacy laws will not cover the information released. Copies of the records may be obtained with reasonable notice and payment of copying cost. I understand this authorization will expire one year from date it was signed. I have carefully read and understand the above, have had any question explained to my satisfaction, and do herein expressly voluntarily authorize disclosure of the above information about or medical records of my condition to those persons or agencies listed above.

_____ _____

Patient or legally authorized individual signature Date

Please FAX this document to Medical Records 303.347.1341

INSIGHT VISION GROUP

Authorization to Verbally Discuss Protected Health Information

**Note: This form is optional. In order for this form to be valid, all information must be completely filled out.*

Patient Name:_____ Date of Birth:_____

I hereby give permission for InSight Vision Group and affiliates to verbally discuss the following medical and billing information about me (check all that apply):

☐ Scheduling/appointment information

☐ Medical information, including my symptoms, diagnosis, medications and treatment plan.

☐ Lab/Test results

☐ Billing and payment information

☐ All information

☐
Other:_____

InSight Vision Group and affiliates has my permission to discuss the above information with:

Name	Phone Number	Relationship to Patient

I understand that I may cancel this permission at any time by notifying InSight Vision Group in writing; however canceling permission will not affect any information that has already been released.

I understand that I do not have to sign this form, and that I should only sign it if I want my medical provider or my clinic to share my information with someone.

_____ _____

Signature of Patient or Parent/Legal Guardian *Date*