INSIGHT VISION GROUP

Name:_______________________________________ Date: ________________________

LIFESTYLE Questionnaire:

1. What is your occupation? ____

2. What are your favorite hobbies? ____

3. Do you do a lot of close detail work such as: sewing/knitting/drawing/etc.? ☐ Yes ☐ No

4. How do you feel about wearing glasses? (please check all that apply)
   ______ I don't mind wearing glasses all day.
   ______ I don't mind wearing glasses for reading/close work.
   ______ I don't mind wearing glasses for TV/driving distances.
   ______ I would like to greatly reduce dependence on glasses for both reading and far distance.

5. Have you ever tried monovision with contact lenses/glasses? ☐ Yes ☐ No

6. Does your vision effect your ability to read or perform computer work? ☐ Yes ☐ No

7. Would you be content knowing you may require glasses for some tasks? ☐ Yes ☐ No

8. Do you consider yourself to be an easy-going person and adaptable to change? ☐ Yes ☐ No

9. How did you hear about us?
   _____ Eye Doctor ________________________________
   _____ Internet
   _____ Friend/Family Member ________________________________
   _____ Saw our signage

10. Do you have an email you would like to share with us? ☐ Yes ☐ No

    If Yes, please provide:____

~Do you have vision insurance?.~ ☐ Yes ☐ No

If yes, please provide:________________________________

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT INFORMATION (Please Print):

Name: ____________________________Date of Birth: ___/____/_____

Address: ____

City: _________________________ State: _________ Zip: _____________

Home Phone: (_____)______-_______ Cell: (_____)______-_______

RELEASE MY MEDICAL RECORDS FROM:

OPTOMETRIST INFORMATION (Please Print):

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RELEASE MY MEDICAL RECORDS TO:

InSight LASIK South ____ 11961 Lioness Way Parker, CO 80134
Phone: 720-880-6455 Fax: 720-880-6460

InSight LASIK North ____ 4430 Arapahoe Avenue Suite 155 Boulder, CO 80303
Phone: 303-402-1000 Fax: 303-593-2199

BY MY SIGNATURE, I AUTHORIZE RELEASE OF MY MEDICAL RECORDS – including, but not limited to, progress notes, operative notes, laboratory results, and diagnostic tests.

Patient 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 the appropriate location: 4430 Arapahoe Avenue., Suite 155, Boulder, CO 80303 - OR - 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______________