6760 Corporate Drive, Suite 180
Colorado Springs, CO 80919
Phone: 719-272-4227 Fax 719-272-3834

PATIENT REGISTRATION FORM

Name: ______________________ ______________________ ____________
Last First Middle

____
What name do you want to be called by?

Address: ____

City: ______________________ State:_____ZIP__________

Phone No: ____________ Cell No: ____________ Other No. ____________

Email: ______________________ Ok to contact by email? YES NO

Date of Birth: ____________ Social Security Number: ______________

Male_________Female_______

Marital Status: ___________ Employer: ______________________

Primary Care Physician: ______________________________________

Emergency Contact (please list name, phone number and relationship): ____________
____

Who will be guaranteeing payment for today's visit? Please list name, address, telephone number and relationship if the patient is not the guarantor. ______________________
____
____
____

Primary Insurance: ______________ Policy Owner: ______________
Policy Number: ______________ Group Number: ______________

Secondary Insurance: ______________ Policy Owner: ______________
Policy Number: ______________ Group Number: ______________

Is the patient a minor? YES NO Does the patient have a legal representative? YES NO
If yes to either, please list name, address and phone number of legal representative.
____
____

HAAS VISION CENTER

1. I authorize Haas Vision Center to release any information regarding my examination and/or treatment to any other physician, insurance company or health organization as required.
2. I authorize any physician, hospital or medical care facility to provide all information regarding my health history and/or treatment to Haas Vision Center.
3. I authorize payment directly to Haas Vision Center for the surgical and/or medical benefits, if any, otherwise payable to me under the terms of my insurance.
4. I understand that I am ultimately responsible for payment for services rendered even though it may be covered by medical insurance, Workers Compensation, or a private agreement with another party.

Patient/Guardian Signature: ______________________________

Date: ______________________________

Haas Vision Center would appreciate if you took the time to let us know how you heard about us.

Please circle all that apply.

Yellowbook Yellow Pages

Dex Yellow Pages (or Dex Online)

KOAA.Com

Facebook

Twitter

Yellowpages.com

Google

Yahoo

Bing

Other: ______________________________

Referred by physician: ____________________

Referred by optometrist: ____________________

Referred by family/friend: ____________________

HAAS VISION CENTER FINANCIAL POLICY

Haas Vision Center is a dedicated medical and surgical practice. Therefore, we do not accept any vision plan insurance. Your exam today WILL be billed under your medical insurance. Please understand that vision insurance will only cover routine vision problems such as near or far-sighted vision, eyeglasses and contacts; vision insurance will not cover medical eye conditions.

Haas Vision Center makes every effort to ensure that we participate with your health insurance. Health insurance companies are continually offering new plans with different networks. Unfortunately, the insurance companies do not always let us know if we are in network; therefore, it is impossible to know for certain that we participate with your insurance. It is the patient's responsibility to ensure we are in network before being seen by Dr. Haas. If your insurance claim comes back as out of network, you will be responsible for all charges as dictated by your insurance company.

Please understand that our financial policies are established to assure the financial resources needed to maintain this medical office for all our patients. We will work with you regarding your financial responsibility.

- We must emphasize that as a health care provider our relationship is with you, not your insurance company.
- Your insurance is a contract between you, your employer, and the insurance company. We bill your insurance company as a courtesy to you, the patient.
- You are responsible for knowing what your co-payments, deductibles and/or co-insurance is with your insurance provider. Please contact your insurance company and/or your employer's human resources department with regards to your benefit questions.

If you have health insurance with which we participate:

- We will bill your insurance claim for you.
- We expect any required co-payment at time of service.
- We expect payment of the deductible and coinsurance to be paid in full after we have issued you a statement to be paid within 30 days unless prior arrangements have been made.

If you are uninsured or we do not participate with your insurance, payment for total charges are due on the day of your appointment unless prior arrangements have been made.

Late Cancellation/No Show Policy

Due to the increased demand for appointment times, it has become necessary to implement a late cancellation/no show policy for office visits. 24 HOUR NOTICE IS REQUIRED FOR ALL CANCELLATIONS. If a patient appointment has been confirmed and the patient fails to keep the appointment, it will be documented in the patient chart and a fee of $35.00 will be assessed to the patient's account.

I have read and accept the terms of this financial policy:

______________________________________ ____/____/____

Patient signature (or person authorized to sign for patient) **Date**

HAAS VISION CENTER

PATIENT NAME: ______________________________

INFORMATION AND CONSENT FOR REFRACTION

It may be important to your care to perform a vision test called a "refraction" to check for your BEST vision today. A refraction is when the examiner determines the prescription required for the patient's eyeglasses by evaluating the effectiveness of a series of lenses through which the patient is asked to view an eye chart. This is accomplished with a phoropter (refractor), a device that contains a range of lens powers that can be quickly changed, allowing the patient to compare various combinations when viewing the eye chart. A lens prescription is issued when the examination is complete.

Medicare, AARP and Medicare Advantage Plans DO NOT COVER refractions. If Medicare does not cover the refraction, neither will most other secondary insurances. The cost for your refraction is $50.00 which will be collected at check-out today.

Some private insurance plans will cover the cost of refractions. Therefore, we will bill your private insurance for the refraction. If the private insurance denies the refraction, we will send you a statement for the cost of the refraction ($50.00).

I understand that if I have a refraction today that the cost of the refraction will be as stated above.

______________________________ ___/___/___

Patient signature (or person authorized to sign for patient) **Today's Date**

PATIENT NAME:____

HAAS VISION CENTER

INFORMATION AND CONSENT FOR DILATED EYE EXAMINATION

It may be important to your care today to dilate your eyes. Dilating eye drops are used to enlarge the pupils of the eye to allow the physician to obtain a better view of the inside of your eyes.

Dilation frequently changes vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for us to predict to what degree your vision will be affected. Driving may be difficult immediately after the examination. If you are concerned about these problems, you may wish to make alternative transportation arrangements, although a large number of patients do drive after dilation with the assistance of temporary sunglasses, which we can provide after your dilation.

Adverse reactions, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize the physician and/or such assistants as may be designed by him to administer dilating eye drops. The eye drops are necessary to perform a complete exam of the retina and the back of the eye. This may reveal the presence of a serious systemic condition as well as eye conditions.

I agree to have the dilation examination on every visit that Dr. Haas deems it necessary to conduct a complete examination of my eyes. I understand that if I decide not to have the dilated examination, I must sign another form revoking my consent for that visit only.

____ ____/____/____

Patient Signature (or person authorized to sign for the patient) **Date**

HIPAA RELEASE OF INFORMATION FORM

Name:_______________________________________DOB: _______/_______/_______

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse ____

[ ] Child (ren) ____

[ ] Other ____

____

[ ] Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

Signed: ____________________________________ Date: _____/_____/_____

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGMENT FORM

I, ______________________________, have read /received/been presented with a copy of the Notice of Privacy Practices.

Signature of Patient:______________________________
Date: ______________________________

Signature of Guardian: ______________________________
Date: ______________________________

FAMILY HISTORY:	YES	NO	FAMILY MEMBER
HIGH BLOOD PRESSURE			
HEART DISEASE			
RESPIRATORY ISSUES			
ARTHRITIS			
STROKES			
DIABETES			
THYROID			
HIGH CHOLESTEROL			
CANCER			
OTHER:			

Have you ever had any surgical procedures before? __________ If Yes, please list procedures and dates.

______________________________ ____________

______________________________ ____________

______________________________ ____________

Do you receive an Flu Vaccine every year? YES NO

Have you had a Pneumonia Vaccine? YES NO

Please list ALL medications (including non prescription) you are currently taking:

______________________ ______________________
______________________ ______________________
______________________ ______________________
______________________ ______________________
______________________ ______________________

Please list all known drug allergies: (If none, please circle None) - NONE

DRUG: **REACTION:**

____
____
____
____

Are you or have your ever been a smoker? YES NO FORMER

Do you drink alcohol? ________ (If yes, how often?) ______________________

	YES	NO	BOTH
Do you currently wear Glasses or Contacts?	YES	NO	BOTH
Have you ever had any eye surgery?	YES	NO	
Have you had Lasik?	YES	NO	

Do you OR any one in your family have any history of the following:

Glaucoma:

Age Related Macular Degeneration:

Retinal Detachment:

Cataracts:

Dry Eyes:

Please mark any condition you have presently or have had in the past:

	YES	NO			
HIGH BLOOD PRESSURE					
HEART DISEASE					
RESPIRATORY ISSUES					
ARTHRITIS					
STROKES					
DIABETES					
THYROID					
HIGH CHOLESTEROL					
CANCER					
OTHER:					

Visual Function Questionnaire

Please Check All That Apply to You

Patient Name: ______________________________

Have you been bothered by:

_____ Blurry vision
_____ Hazy vision
_____ Glare
_____ Poor night vision
_____ Seeing in poor or dim light
_____ Halos
_____ Seeing rings or stars around lights
_____ Frequent changes in glasses

Have you noticed difficulty with your vision when you:

_____ Work at your job
_____ Manage your home
_____ Get around in your home
_____ Watch TV
_____ Use a computer
_____ Read newspapers
_____ Read the telephone book
_____ Read labels
_____ Read price tags
_____ Shop for groceries
_____ Drive during daylight hours
_____ Drive during evening/night hours
_____ See traffic signs
_____ Sew or do crafts
_____ Play golf
_____ Enjoy recreation or leisure
_____ Recognize people
_____ Other ______________________

Patient signature: ______________________________

Date: ____________________ Reviewed by: ____________________

HAAS VISION
CENTER

Vision Lifestyle Survey

Patient Name ______________________________ **DOB** _______

We want to help you maintain excellent vision. We will be evaluating you soon for cataracts. The term "cataracts" refers to a cloudy lens within the eye. When a cataract is removed, a lens implant is used to replace the cloudy natural lens. If it is determined that a lens implant is appropriate for you, your answers below will help in determining which implant best suits the demands of your lifestyle. Please fill this form out completely and bring it with you to your evaluation.

1. If lens replacement is recommended for you, Please rate your vision preferences at the Following distances:

Distance Vision: driving, golf, tennis, other Sports, watching TV

- ☐ Prefer no distance glasses
- ☐ I wouldn't mind wearing glasses for distance

Mid-range Vision: computer, menus, price tags, Cooking, board games

- ☐ Prefer no mid-range glasses
- ☐ I wouldn't mind wearing mid-range glasses

Near Vision: reading books & newspapers, Doing detailed handiwork

- ☐ Prefer no near glasses
- ☐ I wouldn't mind wearing near glasses

2. Please check the single statement that best Describes you in terms of **night vision:**

- ☐ Night vision is extremely important to me And I require the best possible quality.
- ☐ I want to be able to drive comfortably at Night but I would tolerate some slight Imperfections.
- ☐ Night vision is not important to me.

3. If you **had to wear glasses after surgery For only one activity,** for which type of activity Would you be most willing to wear glasses?

- ☐ Distance Vision (driving, watching TV)
- ☐ Mid-range Vision (computer, dashboard)
- ☐ Near Vision (reading fine print)

4. If you could have good distance vision during the day without glasses and good near vision for reading without glasses, but the compromise was That you **might see some halos or rings around lights at night,** would that be ok?

Yes or **No**

5. If you could have good distance vision and Mid-range vision during the day and night without glasses, but the compromise was that you **might need glasses for reading** the finest print at near, would you like that option?

Yes or **No**

6. How many hours per day do you spend:

_____ on the computer?

_____ reading books, newspapers or small print?

_____ driving?

7. List your favorite **hobbies or work activities:**

8. Place an **"X"** on the scale to **describe your Personality** as best you can:

[---]

Easygoing **Perfectionist**

Signature: ______________________________

Date: ______________________________

Pre-Operative Questions for Cataract Surgery

Patient Name: ____

1. Yes or No Have you worn contact lenses within the past two weeks?

   If Yes: Soft Contact Lens', please do not wear for 2 weeks prior to consult
   Hard Contact Lens', please do not wear for 1 month prior to consult

2. Yes or No Have you ever had any eye surgery before? (LASIK, LASEK, PRK, RK, cornea, strabismus etc.)

3. If yes what type of eye surgery: ______________________________________

   If the surgery was LASIK was it for nearsighted or farsighted:______________________

4. Yes or No Have you ever used any of the following medicines (even once) -- circle medicine:
   (usually for prostate or urinary problems)

Flomax or Tamsulosin

Cardura or Doxazosin

Minipress or Prazosin

Hytrin or Terazosin

Saw Palmetto

Uroxatral or Alfuzosin

Rapaflo or Silodosin

Proscar or Finasteride

Avodart or Dutasteride

____ ______/______/______

Patient Signature Date