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

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 $80.00 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 ($80.00).

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**

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 private agreement with another party.

Patient/Guardian Signature: ____

Date: ______________________________

How about us?_______________________________________

Or

Referring physician:__________________________________

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/far-sighted vision, eyeglasses, and contacts; vision insurance will not cover medical eye conditions.

Haas Vision Center makes ever effort to ensure that we participate with your health insurance. Health insurance companies 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 company. It is the patient's responsibility to ensure we are in network before being seen by Dr. Haas. If your insurance claim comes back 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 would with you regarding your financial responsibility.

- We must emphasize that as a healthcare provider our relationship 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 provider and/or your employer's human resources department with regards to your benefits 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 co-insurance to be paid in full after we have issued you the 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

Patient Name:____

Information and Consent for dilated Eye Examination

It may be important to your care today to dilate your eyes. Dilating drops are used to enlarge your 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 light lights become bothersome. It is possible for us to predict to what degree your vision will be affected. Driving may be difficult immediately after the exam. If you are concerned about these problems, you may wish to have alternative transportation arrangements, although several of our patients drive after dilation with the assistance of temporary sunglasses, which are provided after your dilation.

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

I hereby authorize the physician and/or such assistants as may be designated 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 systematic condition as well as eye conditions.

I agree to have the dilation examination on every visit that Dr. Haas deems 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 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: ____________________________

Surprise Billing Disclosure

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain **out-of-pocket costs**, like a **copayment**, **coinsurance**, or **deductible**. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.
"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called **"balance billing."** This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.
"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care - like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.
If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

<u>When balance billing isn't allowed, you also have the following protections:</u>

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

- Generally, your health plan must:
    - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact the No Surprises Help Desk at 1-800-985-3059 regarding federal regulations, or the Colorado Division of Insurance at 1-800-930-3745
Visit cms.gov/nosurprises/consumers for more information about your rights under federal law.

My signature acknowledges receiving this notice and does not waive my rights under the law.

____ ___________________________

Patient Signature Date

Do you currently wear **glasses** or **contacts**?	YES	NO	BOTH
Have you ever had **eye surgery**?	YES	NO	
Have you had LASIK?	YES	NO	

Do you OR anyone in your family have ay 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		
Strokes		
Thyroid		
High Cholesterol		
Cancer		
Other:		

Family History:

Please mark any condition a family member has or have had in the past:

	YES	NO
High Blood Pressure		
Heart Disease		
Respiratory Issues		
Arthritis		
Strokes		
Diabetes		
Strokes		
Thyroid		
High Cholesterol		
Cancer		
Other:		

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

_______________________________________ _______________________________________
_______________________________________ _______________________________________
_______________________________________ _______________________________________
_______________________________________ _______________________________________
_______________________________________ _______________________________________

Do you receive a 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, circle NONE) **NONE**

Drug Reaction

____

____

____

____

____

____

Are you or have you ever been a smoker? YES NO Former

Do you drink alcohol? ________________________ (if yes, how often?) __________________________________