



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

Yellowpages.com

Dex Yellow Pages (or Dex Online)

Google

KOAA.Com

Yahoo

Facebook

Bing

Twitter

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:

	<u>YES</u>	<u>NO</u>	<u>FAMILY MEMBER</u>
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 you ever been a smoker? YES NO FORMER

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



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:

	<u>YES</u>	<u>NO</u>	_____	_____	_____
HIGH BLOOD PRESSURE					
HEART DISEASE					
RESPIRATORY ISSUES					
ARTHRITIS					
STROKES					
DIABETES					
THYROID					
HIGH CHOLESTEROL					
CANCER					
OTHER:					