BOULDER EYE SURGEONS

Donald Keller, MD, Brian Nichols, MD PhD & Kevin Cuevas, MD

Board Certified Eye Physicians & Surgeons

4745 Arapahoe Ave, Suite 100 · Boulder, CO 80303 · Phone (303)444-3000 · Fax (303)444-3226

Patient Information			
Name:	**Preferred Name:**	**Birth Date:**	☐**Male** ☐**Female**
Address:	**City, State, Zip:**		
Email Address:	**Home Phone:**	**Mobile Phone:**	☐**Married** ☐**Single** ☐**Minor Other:**
Primary Care Doctor:	**Referring Doctor:**		

Financially Responsible Party (in absence or denial of insurance coverage)			
Name:	**Social Security #:**	**Birth Date:**	☐**Male** ☐**Female**

Parents' Names (if patient is a minor)			
Mother:	**Birth Date:**	**Father:**	**Birth Date:**

FINANCIAL POLICY FOR BOULDER EYE SURGEONS:

Dr. Keller, Dr. Nichols and Dr. Cuevas are medical/surgical doctors and participate with most medical insurance. We DO NOT participate with any routine vision plans (ie. Vision Service Plans (VSP), CVC, DAVIS, etc.). If there is a medical diagnosis found during your exam, your insurance company will be billed accordingly. *We do, however, work with many optometrists that participate in routine vision plans. Please ask us, and we would be happy to assist you in finding one in your area.*

Your insurance policy is a contract between you and your insurance company. We are not a party of that contract, and are unaware of your possible benefits. Please be aware that some, perhaps all, of the services provided may be non-covered services under your contracted plan, and you will be fully responsible for payment.

If your medical insurance has vision benefits through a third-party carrier, you will be responsible for the charges at the time they are rendered. Since most medical plans do not cover contact lenses, fitting fees, or any other associated costs are your responsibility and we require these to be paid at the time services are rendered. We will be glad to give you a copy of the bill so that you may submit it for reimbursement. I hereby authorize release of any information including the diagnosis and the records of any treatment or examination rendered to me or my dependant or child during the period of such cared to third party payors and/or health care providers. I authorize and request payment of insurance benefits otherwise due me directly to Boulder Eye Surgeons, PC. I acknowledge receipt of Notice of Privacy Practices (HIPAA) from Boulder Eye Surgeons.

I UNDERSTAND THAT IT IS MY RESPONSIBILITY:

1. **To provide the office with a current insurance card.**
2. **Payment will be made at the time of service if I do not have my insurance card with me.**
3. **If I have been asked to secure payment by credit card, I understand that the card will not be charged until the insurance company has processed my claim.**
4. **I understand that I am financially responsible for any charges that are not covered by my health insurance plan or for any balance due following insurance payment. Co-payments are due at the time of the visit as is full payment for non-insured patients. I understand that I am responsible for any legal and/or collection fees should my account become past due.**

Signature:_____ Date:_____

(Patient/Responsible Party)

PLEASE COMPLETE BOTH SIDES

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HIPAA PATIENT ACKNOWLEDGEMENT

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement but, in refusing we **will not be allowed** to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for Boulder Eye Surgeons. A copy of this signed, dated Acknowledgement shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTORS IN THE FUTURE.**

_____ _____

Please **print** your name Please **sign** your name

_____ _____

Legal Representative Description of Authority

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTHCARE INFORMATION (This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY HEALTHCARE APPOINTMENTS, TREATMENT & BILLING INFORMATION, INFORMATION ABOUT MY HEALTH AND SPECIAL SERVICES, EVENTS OR NEW HEALTHCARE INFO.**

- o Approve
- o Disapprove (If you opt out of all communications, you will not receive a reminder call for future appointments and you will be responsible for no-show fees.)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorise, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representative's) signature on this Acknowledgement but did not because:

- o It was emergency treatment
- o The patient refused to sign
- o Other (please describe)
- o I could not communicate with the patient
- o The patient was unable to sign because

  _____

_____

Signature of Privacy Officer