Please bring the following with you to your appointment - the information you provide will help us serve you:

- **Photo Identification (required).**
- Enclosed questionnaire completed with your information.
- A list of all medication you take or the medication itself.
- Glasses and/or contact lenses, if you wear them.
- Current insurance card or cards.
- **Referral**, if needed, from your HMO/primary care physician.

It may be necessary to dilate your eyes during your examination or treatment. Dilation results in light sensitivity and may cause difficulty seeing well at close range and/or distance for a few hours or longer. After dilation, patients should wear sunglasses and be cautious while walking, going up or down stairs, driving, or using dangerous machinery. It is at your discretion to determine if you need someone to drive you after your appointment.

Thank you for your assistance. We look forward to seeing you.

Sincerely,

Corneal Consultants of Colorado, P.C.

ALL CO-PAYS, DEDUCTIBLES, AND SELF-PAY AMOUNTS ARE DUE AT THE TIME OF SERVICE.
# Review of Systems

Please indicate any symptoms you are currently experiencing, or have experienced within the last month. Check all that apply:

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Symptom</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Poor vision</td>
<td>□ Upset stomach</td>
</tr>
<tr>
<td>□ Eye pain</td>
<td>□ Diarrhea</td>
</tr>
<tr>
<td>□ Tearing</td>
<td>□ Constipation</td>
</tr>
<tr>
<td>□ Redness</td>
<td>□ Burning on urination</td>
</tr>
<tr>
<td>□ Jaw pain</td>
<td>□ Urinary frequency</td>
</tr>
<tr>
<td>□ Scalp tenderness</td>
<td>□ Incontinence</td>
</tr>
<tr>
<td>□ Amaurosis fugax</td>
<td>□ Joint pain</td>
</tr>
<tr>
<td>□ Loss of vision</td>
<td>□ Stiffness</td>
</tr>
<tr>
<td>□ High blood pressure</td>
<td>□ Rash</td>
</tr>
<tr>
<td>□ Congestion</td>
<td>□ Changing moles</td>
</tr>
<tr>
<td>□ Wheezing</td>
<td>□ Headache</td>
</tr>
<tr>
<td>□ Shortness of breath</td>
<td>□ Seizure</td>
</tr>
<tr>
<td>□ Arthritis</td>
<td>□ Stroke</td>
</tr>
<tr>
<td>□ Diabetes</td>
<td>□ Paralysis</td>
</tr>
<tr>
<td>□ Allergies</td>
<td>□ Anxiety</td>
</tr>
<tr>
<td>□ Fever</td>
<td>□ Depression</td>
</tr>
<tr>
<td>□ Chills</td>
<td>□ Insomnia</td>
</tr>
<tr>
<td>□ Weight loss</td>
<td>□ Thyroid abnormalities</td>
</tr>
<tr>
<td>□ Stuffy nose</td>
<td>□ Bleeding</td>
</tr>
<tr>
<td>□ Earache</td>
<td>□ Anemia</td>
</tr>
<tr>
<td>□ Cough</td>
<td>□ Hay fever</td>
</tr>
<tr>
<td>□ Dry mouth</td>
<td>□ Hives</td>
</tr>
<tr>
<td>□ Rapid heart beat</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name:</th>
<th>DOB:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Date:</td>
</tr>
</tbody>
</table>

ROS 062014
**PAST MEDICAL HISTORY:** Check any you have/have had OR check here if None

- Anxiety
- Arthritis
- Asthma
- Atrial Fibrillation (Irregular Heartbeat)
- Bone Marrow Transplantation
- BPH (Enlarged Prostate)
- Breast Cancer
- Colon Cancer
- COPD (Chronic Breathing Problems)
- Coronary Artery Disease (Heart Disease)
- Depression
- Diabetes: How long? _____ years
  Dr.?_____________Where?_____________
- End Stage Renal Disease
- GERD (Acid Reflux)
- Other

**Past Surgeries:** Check any you have had OR check here if None

- Appendix
- Bladder
- Breast: (Circle One) Mastectomy, Lumpectomy, Biopsy, Reduction, Implants: Right or Left
- Colon: (Circle One) Cancer, Diverticulitis, Inflammatory Bowel Disease, Other
- Gallbladder
- Heart: (Circle One) Bypass Surgery, Stents, Catheterization, Angioplasty, Valve Replacement, Transplant, Other
- Joint Replacement: (Circle One) Knee: Right or Left; Hip: Right or Left
- Kidney: (Circle One) Biopsy, Removal, Stone Removal, Transplant, Other
- Ovaries: (Circle One) Endometriosis, Cyst, Cancer, Other
- Prostate: (Circle One) Cancer, Biopsy, TURP, Other
- Skin: (Circle One) Skin Biopsy, Basal Cell, Squamous, Melanoma
- Spleen
- Testicles: (Circle One) Removal, Cancer
- Uterus: (Circle One) Fibroids, Hysterectomy, Cancer, Other
- Other

**OCULAR HISTORY:** Check Left, Right, or Both for any you have/have had OR Check here if None

- Allergic Conjunctivitis (Pink Eye) □R □L □B
- Blepharitis □R □L □B
- Cataract □R □L □B
- Contact Lenses □R □L □B
- Corneal Dystrophy □R □L □B
- Diabetic Retinopathy □R □L □B
- Dry Eyes □R □L □B
- Glasses
- Glaucoma □R □L □B
- Macular Degeneration □R □L □B
- Narrow Angles □R □L □B
- Ocular Hypertension □R □L □B
- Ocular Migraine
- Retinal Tear □R □L □B
- Strabismus (Eye Muscle Misalignment) □R □L □B
- Vitreous Floaters □R □L □B
- Other

Patient Name (please print):
DOB:
Date:

*** COMPLETE BOTH SIDES ***
Ocular Surgery: Check any you have had OR check here if None □
- □ Blepharoplasty □ R □ L □ B
- □ Cataract Surgery □ R □ L □ B
- □ Corneal Transplant □ R □ L □ B
- □ Eye Muscle Surgery □ R □ L □ B
- □ Intravitreal Injections □ R □ L □ B
- □ LASIK (Refractive Laser) □ R □ L □ B
- □ LPI (Laser for Narrow Angles) □ R □ L □ B
- □ LTP (Laser for Open Angle Glaucoma) □ R □ L □ B
- □ Ptosis Repair □ R □ L □ B
- □ Punctal Plugs □ R □ L □ B
- □ Retinal Laser □ Diabetes/Tear □ R □ L □ B
- □ YAG Capsulotomy □ R □ L □ B
- □ Other

Family History: Check any for which you have an immediate family history OR check here if None □
- □ Blindness □ Cancer □ Cataracts □ CVA (Stroke) □ Diabetes □ Glaucoma □ Other
- □ Heart Disease □ Hypertension (High Blood Pressure) □ Macular Degeneration □ Migraines □ Retinal Detachment □ Strabismus

MEDICATIONS: List below (prescribed, non-prescribed, and over-the-counter) OR check here if None □

ALLERGIES: List below OR check here if None □

SOCIAL HISTORY: Check any that apply.
- □ Illegal Drug Use

   Alcohol Use: Check one.
   - □ None
   - □ Less than 1 drink/day
   - □ 1 to 2 drinks/day
   - □ 3 or more drinks/day

Smoking Status: Check one.
- □ Current every day smoker
- □ Current occasional smoker
- □ Former smoker
- □ Never smoked

Driving Status: Check one.
- □ Drive daytime
- □ Drive nighttime
- □ Drive daytime and nighttime
- □ Do not drive

Occupation: Check here if retired □

Workplace:

Race/ethnicity patient information is a Government requirement for practices using electronic health records.

Race:
- □ White
- □ American Indian/Alaska Native
- □ Asian
- □ Black or African American
- □ Native Hawaiian or other Pacific Islander
- □ Other race

Ethnicity:
- □ Hispanic or Latino
- □ Not Hispanic or Latino

Preferred Language:
- □ English
- □ Other

* * * COMPLETE BOTH SIDES * * *
Patient Name: _______________________________ Date of Birth: ______________________

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I received CORNEAL CONSULTANTS OF CO’s Notice of Privacy Practices.

_________________________________________   ____________________________
Signature of patient or patient representative   Date

DOCUMENTATION OF GOOD FAITH EFFORTS
To obtain patient’s acknowledgment that they received provider’s Notice of Privacy Practices

(For use when acknowledgment cannot be obtained from the patient.)

The patient presented to the office/hospital on ____________________ and was provided with a copy of Covered entity’s Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgment of his/her receipt of the Notice. However, such acknowledgment was not obtained because:

☐ Patient refused to sign.

☐ Patient was unable to sign or initial because:
   __________________________________________________
   __________________________________________________

☐ The patient had a medical emergency, and an attempt to obtain the acknowledgment will be made at the next available opportunity.

☐ Other reason (describe below):
   __________________________________________________
   __________________________________________________

_________________________________________   ____________________________
Signature of Employee Completing Form   Date

Patient Name: _______________________________ DOB: ______________________
CORNEAL CONSULTANTS OF COLORADO, P.C.  
FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require you read and sign prior to any treatment.

All patients must complete our Information and Insurance form before seeing the doctor.

CO-PAYMENT IS DUE AT TIME OF SERVICE. 
WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, DISCOVER, or AMERICAN EXPRESS

Regarding Insurance:

We may accept assignment of insurance benefits. Any balance due after your insurance company has paid their portion or denied payment is your responsibility. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We cannot bill your insurance company unless you give us current and correct information which includes a copy of your current insurance identification card, your social security number, your full and legal name and current address. If extended payments are required, arrangements must be made prior to treatment. Please be aware that some, and perhaps all, of the services provided may be non-covered services and are not considered reasonable and necessary under the Medicare Program and/or other medical insurance.

Regarding Insurance Plans where we are a participating provider: All co-pays and deductibles are due prior to treatment. In the event that your insurance coverage changes to a plan where we are not participating providers, refer to the above paragraph.

Usual and Customary Rates:

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 insurance company’s arbitrary determination of usual and customary rates.

Adult Patients:

Adult patients are responsible for payment.

Minor Patients:

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa, Mastercard, Discover, American Express or payment by cash or check at time of service has been verified.

Miscellaneous fees:

A billing/charge fee of $15.00 per month will be added to all accounts that are 60 days or more past due. We also charge a $20.00 fee for all returned checks. Without 24 hours notification a $25.00 missed appointment fee will be charged. Failure to pay your copay at the time of service will result in a $15.00 billing charge.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.

I have read the Financial Policy. I understand and agree to the Financial Policy:

_________________________________________  ________________________________
Patient Name  Date

_________________________________________  ________________________________
Signature of Patient or Responsible Party
Vision Eye Exam (Routine Visit):

These examinations determine if vision can be improved with glasses or contact lenses and screen for eye diseases.

Medical Eye Exam:

These are examinations for diagnosis and treatment of eye diseases.

Refraction:

Refraction is the optical determination of the best possible eye vision. It is needed to determine if any medical, optical, or surgical treatment may be indicated. It is NOT a covered service by most insurance plans. Our office fee for refraction is $35. Payment for the Refraction will be due today in addition to any copayments, deductibles or other non-covered services.

PLEASE CHECK BELOW AND SIGN FOR THE TYPE OF INSURANCE WE ARE BILLING

_____VISION  _____MEDICAL

If a refraction is done to get a prescription for glasses or contacts, you will be charged a $35 fee for the refraction.

If needed, do you want to receive an eyeglasses or contact lens prescription today?

YES / NO ______________ INITIALS

Refraction must be performed in order to obtain a prescription.

I understand that I am responsible to pay all non-covered services including refractions, co-pays, deductibles and co-insurances. I understand that I am responsible for providing the correct insurance information at the time of service – failure to do so may result in non-payment by the insurance and charges will be my responsibility to pay.

Patient Name: _____________________   DOB:______________

Patient/Responsible Party

Signature:______________________________Date:____________
ASSIGNMENT OF BENEFITS

I hereby assign to Corneal Consultants of Colorado any insurance or other third-party benefits available for healthcare services provided to me. I understand that Corneal Consultants of Colorado has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Corneal Consultants of Colorado, I agree to forward the Practice all health insurance and other third-party payments I receive for services rendered to me immediately upon receipt.

___________________________________________________________
Print Name

DOB

___________________________________________________________
Signature of Patient/Legal Guardian

Date