RetinaSpecialists
OF COLORADO

Demographic Information

Patient Name:_____ Sex: M____ F____

Date of Birth (mm/dd/yyyy) ____/_____/_____ Social Security Number: _____-_____-_____

Home Phone:_____-_____-_____ Cell Phone:_____-_____-_____

Email:_____

Mailing Address:_____ City:_____ State:_____Zip:_____

Emergency Contact Name/Phone:_____ Relationship: _____

Referring Doctor: (Name, Phone and Fax):_____

Primary Care Physician:(Name, Phone and Fax)_____

Insurance Information

Please bring your current insurance cards to every visit.
It is your responsibility to keep your insurance information up to date and verify that **Retina Specalist of Colorado** is in-network with your insurance plan.

Primary Insurance Carrier:_____ Primary Member ID:_____

Insurance Guarantor Name:(If different than patient)_____Insurance Guarantor DOB:_____

Secondary Insurance Carrier:_____ Secondary Member ID:_____

Do you have Medicaid: Y:____ N:_____

If YES please provide Medicaid card to the front desk.

Retina Specialists of Colorado will utilize the above demographic and insurance information for billing and documentation purposes. I confirm that the above information is accurate and up to date.

SIGNATURE (PATIENT) _____

DATE _____

Retina Specialists of Colorado
Phone: 720-443-2425
Fax: 720-328-5369

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MEDICAL HISTORY

Allergies:

Medical History:

Current Medications:

Eye/Ophthalmic History:

Eye Surgeries:

Other Surgeries:

Family Medical History:

Family Eye History:

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History of Kidney/Renal Disease: YES NO

History of Hepatitis: YES NO Type of Hepatitis:_____

History of HIV: YES NO

History of COVID: YES NO Date:_____

History of COVID Vaccination: YES NO

SOCIAL HISTORY:

Smoking: YES FORMER NO Packs per day:_____

Alcohol: YES NO Drinks per day:_____

Drug Use: YES NO Type:_____

Pregnant: YES NO

ADDITIONAL INFORMATION

Retina Specialists of Colorado is a retinal medical practice. All patients will have both eyes dilated unless otherwise recommended by the doctor. Dilating drops make your eyes more sensitive to light and decrease the ability to accommodate or see small letters or focus on objects that are near. Dr. Chod, Dr. Jansen, and Dr. Koretz caution all patients against driving a motor vehicle until dilating drops have worn off; to do so would be at my own risk.

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ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I understand that under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used for the purposes of conducting and coordinating care, obtaining payment, and supporting healthcare operations of Retina Specialists of Colorado.

I acknowledge that I have received the Notice of Privacy Practices, which provides a comprehensive explanation of how my protected health information may be used or disclosed. I was given the opportunity to review the notice prior to signing this consent.

I understand that Retina Specialists of Colorado has the right to change its Notice of Privacy Practices from time to time, and that I may contact this organization at any time to obtain the most current copy of the Notice of Privacy Practices.

I understand that I may request in writing restrictions on the use or disclosure of my protected health information. I also understand that Retina Specialists of Colorado is not required to agree to my requested restrictions, but are bound to abide by such restrictions upon agreement.
I understand that I may revoke my consent to use and disclose my protected health information upon written request. Any use or disclosure that has already occurred prior to the date of revocation request is received will not be affected.

As per HIPAA, Retina Specialists of Colorado reserves the right to decline service if the consent form is not signed.

I HAVE READ AND UNDERSTAND THIS CONSENT. I CONSENT TO THE USE AND DISCLOSURE OF MY HEALTH INFORMATION IN ACCORDANCE TO THE NOTICE OF PRIVACY PRACTICES.

SIGNATURE (PATIENT) _____

DATE _____

SIGNATURE OF PATIENT REPRESENTATIVE_____

DATE _____

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FINANCIAL ASSIGNMENT AND AGREEMENT

INSURANCE

Our policy is to bill insurance as a courtesy for all of our patients. In order to bill your insurance claims correctly for all appointments, we require that you provide a copy of your current insurance card, social security numbers of the patient and responsible party, a picture ID, and a current mailing address that matches the address on file with your insurance carrier. **If you cannot provide your insurance card, you must pay for your visit in full at the time of service.** If prior authorization or unique claim forms are required, it is your responsibility to obtain this prior to your visit. It is important to remember that insurance is a contract between the patient and the insurance company, and ultimately the patient is responsible for payment in full. If your insurance company does not pay the practice within a reasonable period of time, you will be billed. If we later receive payment from your insurer, we will refund any overpayment to you.

PATIENT RESPONSIBILITY

Any fees collected at the time of service and any quotes regarding such fees are estimated based on the information available to us at the time of service. We rely on information provided by the responsible party regarding insurance coverage. If the insurance information you provide is incorrect, you will be responsible for payment of the visit and submitting charges to your insurance company for reimbursement. We can never guarantee that your insurance will cover all services or administered medications, even if verified, until our office receives the actual explanation of benefits (EOB.) It is best for you to understand your insurance plan before services and/or products are delivered to prevent misunderstanding. It is the responsibility of the patient to verify in-network benefits with their insurance company prior to being seen by office. While our office will make every effort to avoid out of network billing, patients who are seen out of network may be responsible for these out of network charges. Our office will alert you of out of network status whenever possible.

PAYMENT

All copayments, deductibles, and coinsurance amounts are due at the time of service. It is our policy to render periodic statements for services and products on a monthly basis. Any account balance that is not paid in full within 60 days of the due date (i.e. the date of service) may be forwarded to an outside agency for collections. All costs of collections, including attorney fees, collection fees of 30% and court costs are the responsibility of the patient. Any unpaid balance will be assessed interest at the rate of 18.00% (1.5% monthly.) Insurance claims are filed to patient insurance companies as a courtesy, but it is the patient's responsibility to see that the claims are paid on time. Any account balance that remains unpaid after transfer to a collections agency may be eligible for reporting to a credit bureau. For your convenience, we accept cash, check, money orders, debit cards, and most credit cards. Returned checks will incur an additional $25 fee.

SIGNATURE_____

DATE_____

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WAIVER OF PATIENT RESPONSIBILITY

It is the policy of the practice to treat all patients in an equitable fashion related to account balances. The practice will not waive, fail to collect, or discount co-payments, co-insurance, deductibles, or other patient financial responsibilities in accordance with federal and state law, as well as participating agreements with payers.

PATIENTS WITH HMO OR POS INSURANCE PLANS STATEMENT

As a member of an HMO or POS insurance plan, I am aware that I am required to bring my insurance card and obtain a referral in order to receive benefits for specialty care from Retina Specialists of Colorado. If I do not have a valid referral or authorization from my insurance company, I understand that I am fully responsible for all charges incurred. Without a valid referral, financial responsibility will lie upon the patient and full payment will be due at the time of service.

RELEASE

I hereby authorize Retina Specialists of Colorado, its doctors, and/or agents to apply for reimbursement benefits on my behalf for services rendered to me. I understand that payment from my insurance carrier will be made directly to Retina Specialists of Colorado. I further authorize the release of any information necessary, including but not limited to any medical information, in order to process any claim with my insurance carrier. I understand that I am financially responsible for all charges, including those not covered by my health insurance. I further understand that I will be responsible to pay for any service denied by my insurance company. I authorize the use of this signature on all insurance submissions. I understand that I am responsible for all co-payments, deductibles, co-insurance, non-covered services, and/or amounts exceeding any maximum benefits outlined by my insurance plan and that such payments are due at the time of service. I understand that in the event my insurance company does not pay for services rendered by Retina Specialists of Colorado, I agree to accept full financial responsibility for any direct or ancillary charges for services rendered on behalf of myself and/or my dependents.

I have read, understand, and agree to the Financial Policy Statement above in its entirety.

SIGNATURE (PATIENT) _____

DATE _____

SIGNATURE OF PATIENT REPRESENTATIVE_____

DATE _____

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Metro Cancellation and No-Show Policy

We would like to thank you for choosing our office for your retinal care. As we continue to prioritize providing high-quality, timely care to all our patients, we have found it necessary to update our cancellation and no-show policy. This change is in response to a recent increase in missed appointments, which impacts our ability to accommodate other patients.

Cancellation & No-Show Fees:

- Cancellations made **less than 24 hours** in advance will incur a **$35 fee**, charged to your account.
- **Same-day cancellations or no-shows** will incur a **$50 fee**, charged to your account.

We understand that unexpected things happen, but in fairness to our team and other patients waiting for appointments, we kindly ask that you let us know as soon as possible if you need to reschedule.

By signing below, you acknowledge and agree to this cancellation and no-show policy, and authorize Retina Specialists of Colorado to charge your card on file if applicable.

Print Name: _____

Signature: _____

Date: _____

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