MILE HIGH EYE INSTITUTE

William Richheimer, MD
Zachary Vest, MD
Leonid Zukin, MD
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Madeline Graber, OD
Audrey Hudson, OD
Lisa Reyes, OD
Alaina Jacobsen, OD
Pearl Shin, OD

# Patient Registration Form

## Patient Demographics

Name:_____ DOB: ____/____ /____

By what name would you like the doctor to address you: _____

Phone:Cell:_____Home:_____Work:_____

Address:_____City:_____State:_____Zip code:_____

Email*:_____ SSN#:_____

**(*By providing your email address, you consent to contact via email.)**

Preferred Contact Method: □Phone □Email □Postal Preferred Phone: □Cell □Home □Work

Marital Status: □Single □Married □Widowed

Preferred language: □English □Spanish □Other_____

Occupation_____ Employer_____

Emergency Contact_____ Phone_____ Relation_____

## Medical Decision Making

□ I am my own medical decision maker, I do not have a power of attorney

□ I have a power of attorney who makes medical decisions for me and who signs medical forms.

POA Name _____ Phone:_____

If you have a power of attorney who makes medical decisions for you, our doctors require that this person be present at every exam, consultation and surgery. **POA paperwork must be provided to our office.**

## Insurance Data

Primary Ins. Carrier:_____ Secondary:_____

Subscriber's Name:_____ DOB:____/____ /____

Insured SSN#:_____ □ Self □ Spouse □ Parent □ Other:_____

## Consult Information

Who may we thank for referring you?

□ Doctor_____
□ Friend (specify) _____
□ Website _____
□ Other _____

What is the primary reason for your visit today?

_____

*In order to meet "Meaningful Use" criteria as set forth by the Federal Government, we are required to obtain the following information: race, ethnicity, preferred language, gender, and date of birth.

## Gender Identity/Race Data*

□ Male □ Female □ _____

Race:
□White/Caucasian
□Native American
□Native Hawaiian / Pacific Islander
□Black or African American
□Asian
□Other:_____
□Prefer not to respond

Ethnicity:
□Hispanic or Latino
□Not Hispanic or Latino
□Other:_____
□Prefer not to respond

**Primary Care Physician**

Name_____

Phone_____ Address_____

**Insurance Authorization**

With my signature below, I hereby authorize all of my insurance companies to make payment directly to Mile High Eye Institute. This assignment will remain in effect until revoked by me in writing. I understand that I have primary financial responsibility for all charges whether or not paid by an insurance company. I authorize the release of any medical information necessary to process these claims. Further, I acknowledge receipt of and agree to abide by Mile High Eye Institute's Financial Policy.

**Patient/Authorized Representative Signature _____ Date_____**

**Consent for Treatment**

With my signature below, I hereby authorize Mile High Eye Institute to examine and treat me, or the individual for whom I am responsible. I understand my eyes may be dilated during the course of an examination. *If you do not feel comfortable driving after you have been dilated, please decline dilation or allow time for the effect of the dilating drops to wear off.

**Patient/Authorized Representative Signature _____ Date_____**

**Patient Code of Conduct**

In an effort to provide a safe and healthy environment for staff, visitors, patients and their families, Mile High Eye Institute expects visitors, patients and accompanying family members to refrain from unacceptable behaviors that are disruptive or pose a threat to the rights or safety of other patients and staff. The following behaviors are prohibited:

- Possession of firearms or any weapon
- Rude behaviors in person or through written, verbal or electronic communication, including but not limited to the following: profanity, harassment, offensive or intimidating statements or gestures, threats of violence
- Physical assault or inflicting bodily harm
- Making verbal threats to harm another individual or destroy property
- Racial or cultural slurs or other derogatory remarks associated with, but not limited to, race, language or sexuality

If you are subjected to any of these behaviors or witness inappropriate behavior, please report to any staff member. Violators are subject to removal from the facility and/or discharge from the practice.

*Adults are expected to supervise children in their care.

**Patient/Authorized Representative Signature_____ Date_____**

**Medicare Patients**

After you are seen by the doctor, Mile High Eye Institute will submit a completed insurance form to Medicare. Their guidelines permit us to obtain a one-time signature that is valid for this and future visits to our office. By signing below, the notation "SIGNATURE ON FILE" will appear in lieu of your signature on all Medicare forms submitted for you by our office.

**Patient/Authorized Representative Signature_____ Date_____**

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# Medical History Form

## Patient Data

Patient Name:_____

DOB: ____/____ /____ Today's Date: ____/____ /____ Date of Last Eye Exam: ____/____ /____

Are you using any eye drops? ☐ No ☐ Yes If YES, please list:

| Drop Name | Eye | Frequency |
|---|---|---|
| | | |
| | | |
| | | |

Other eye medications:

_____

_____

Please list any other medications you are taking (including over-the-counter, vitamins, and herbs)? ☐ None

_____

_____

## Personal History

Drug Allergies? ☐ None Known ☐ Yes (if Yes, list below)

Allergy: _____ Reaction:_____
Allergy: _____ Reaction:_____
Allergy: _____ Reaction:_____

Please list your current:

Height: _____

Weight:_____lbs

Please √ any eye conditions you have or have had in the past: ☐ None

☐ Cataracts ☐ Macular Degeneration [List treatments performed in past: ☐ None ☐ Other_____]

☐ Glaucoma ☐ Dry Eye ☐ Keratoconus ☐ Pterygium/Pinguecula

☐ Other (please list) _____

Have you ever had eye surgery? ☐ No ☐ Yes - If YES, type(s) and date(s)?:

☐ LASIK _____ ☐ PRK _____ ☐ RK _____ ☐ Other refractive procedure:_____

☐ Cataract surgery: Date_____ Surgeon_____

Other eye surgery:_____

Please √ any major illnesses: ☐ Asthma ☐High Blood Pressure ☐ High Cholesterol ☐ Heart Attack

☐ Diabetes Type 1 or 2 [Most recent Hemoglobin A1C: ☐ Less than 7 ☐ Between 7-9 ☐Above 9]

☐ Migraines ☐ Cancer, Type:_____ ☐ Stroke, When?:_____

Other diagnosed medical conditions or conditions you are being treated for:

_____

Have you ever had any non-eye related surgeries in the past? ☐ None ☐ Yes - If YES, type(s) and date(s)?:

_____

_____

_____

## Review of Systems

### Current Health Status

Please circle any of the following that you are *currently* experiencing:

***Eyes***
Poor Vision
Eye Pain
Redness

***Constitutional***
Fever
Chills
Weight Loss/Gain

***ENT and Mouth***
Stuffy Nose
Ear Ache
Cough
Dry Mouth

***Cardiovascular***
High/Low Blood Pressure
Rapid Heart Beat

***Respiratory***
Congestion
Wheezing
Shortness of Breath

***Gastrointestinal***
Upset Stomach
Diarrhea
Constipation

***Genitourinary***
Burning on urination
Urinary Frequency
Incontinence

***Musculoskeletal***
Joint Pain
Stiffness
Arthritis

***Neurological***
Headaches
Seizure
Stroke
Paralysis

***Psychological***
Anxiety
Depression
Insomnia

***Endocrine***
Diabetes: A1C____
Thyroid Abnormalities

***Hematologic***
Bleeding
Anemia

***Allergic/Immunologic***
Food Allergies
Drug Allergies
Hay Fever

***Skin***
Persistent Itch
Skin Rash

***For Females:***
Pregnant
Breastfeeding

***Other Medical Conditions:***
***Describe:***

_____

_____

_____

### Immediate Family History
**(Mother, Father, Sibling)**

Please note which family members have had the following:

| Condition | Family Member |
|---|---|
| Blindness | |
| Cataract | |
| Glaucoma | |
| Stroke | |
| Breast Cancer | |
| Prostate Cancer | |
| Skin Cancer | |
| Diabetes | |
| Hypertension | |
| Other: | |

### Social History

Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)? ☐ Yes ☐ No

If YES, explain: _____

Do you drink alcohol? ☐ Yes ☐ No

If YES, how much?:_____

Do you use any street or recreational drugs? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No

Have you ever smoked in the past? ☐ Yes ☐ No

If YES, how much?:_____per day

For how many years?:_____

### Preferred Pharmacy

Pharmacy Name:_____

Pharmacy Phone _____ Pharmacy Cross Streets_____

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# HIPAA Medical Information Release Form

**Patient Name: _____ DOB: _____/_____/_____**

## Release of Information

I authorize the release of information including diagnosis, records, examination rendered to me, and claims information. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in Mile High Eye Institute's Notice of Privacy Policies.

I would like to designate the following individuals with whom my health information may be shared (please list names):

[ ] Spouse _____

[ ] Child(ren) _____

[ ] Other _____

[ ] Information not to be released to anyone.

**This Release of Information will remain in effect until terminated by me in writing.**

## Messages

I authorize Mile High Eye Institute to contact me for the purposes of scheduling, communicating results, findings, and care decisions.

Please call (check all that apply): [ ] Cell Phone: _____

[ ] Home Phone: _____

[ ] Work Phone: _____

If unable to reach me: [ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

**Patient/Authorized Representative Signature_____ Date _____**

# Financial Policy

Thank you for choosing Mile High Eye Institute as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is required for treatment with us. We are happy to discuss professional fees with you at any time, as your clear understanding of our Financial Policy is essential to a successful professional relationship. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment.

**All patients must complete our Patient Registration form before seeing the doctor**.

****PAYMENT IS DUE AT TIME OF SERVICE**

****WE ACCEPT CASH, CHECKS, VISA/MASTERCARD, AMERICAN EXPRESS, DISCOVER, GREENSKY and CARECREDIT**

**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. If you are a member of an insurance plan with which we participate, we will file the insurance claim for you. However, 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. Your responsibility will be your co-pay, (if any), the amount your insurance company deems your responsibility, your deductibles, and any denials for services not covered under your policy. All co-pays are due prior to any treatment and estimated co-insurance and/or deductibles are due prior to any surgical treatment. Should your insurance delay payment for more than sixty days, you may be held responsible for full payment of the amount charged. If an extended payment plan is required, arrangements must be made prior to treatment. Please be aware that some, and perhaps all, of the services provided may be considered non-covered services by your insurance company. **ALL INSURANCE COVERAGE IS A MATTER BETWEEN THE PATIENT AND THE INSURANCE COMPANY. IF THE PATIENT'S POLICY REQUIRES, THE PATIENT IS ULTIMATELY RESPONSIBLE FOR A CURRENT AND VALID REFERRAL AND/OR PRECERTIFICATION PRIOR TO ANY PROCEDURE OR OFFICE APPOINTMENT. IF NO REFERRAL AND/OR PRECERTIFICATION ARE RENDERED, THE BALANCE IS THE PATIENT RESPONSIBILITY.**

**Medicare:**

Our billing department will file your claim with Medicare. Supplemental insurance is billed as a courtesy. If no payment is received within 60 days, the balance becomes the patient responsibility. Advance Beneficiary Notice (ABN) is required by Medicare and will be provided to patients when Medicare is not likely to pay for certain services.

**Contact Lens Fittings/Other Supplies:**

Payment for contact lenses, fittings, or other supplies are the responsibility of the patient. Payment in full will be required prior to ordering lenses and supplies, or in some cases, may be paid at the time of dispensing materials and/or supplies.

**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.

**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 payment is rendered at the time of service.

**Refraction Code (92015)**

A refraction code consists of checking the visual acuity and determining the optical correction required for best visual functioning. It is often performed in routine, medical, and post-operative examinations. **Our office charge is $50 for this component of the exam.** A refraction is considered an out-of-pocket expense by most insurance companies, and hence is the responsibility of the patient for a routine, medical, or post-operative examination.

**Miscellaneous fees:**

If you are unable to make an appointment, you are required to give us advanced notice. Failure to do so will result in a **$25.00 missed appointment fee** that will be charged to your account. We also charge a **$25.00 fee for all returned checks**. You are responsible for any costs of collection, including attorney fees, collection fees, and court costs. Unpaid balances may be charged 1.5% per month or 18% annually.

**I hereby authorize MHEI and its employees, agents, and assignees to communicate with me by telephone, text, email, or other means regarding any balance due, as necessary.**

**By signing, I acknowledge I have been presented with and agree to abide by this Financial Policy. This assignment will remain in effect until removed by me in writing. I understand that I have primary responsibility for any referrals needed and all charges whether or not paid by an insurance company. I authorize the release of any medical information necessary to process these claims.**

**Patient/Authorized Representative Signature: _____ Date: _____**

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# Notice of Privacy Policies

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA), Mile High Corneal Specialists, P.C. (Practice) may not use or disclose your personal health information without your authorization.

**THE PRACTICE HAS POLICIES AND PROCEDURES TO COMPLY WITH HIPAA LAW. EVERY ATTEMPT HAS BEEN MADE TO KEEP THE PROCESS FOR PATIENTS AND STAFF AS EFFICIENT AS POSSIBLE. HOWEVER, THE REQUIREMENTS ARE EXTENSIVE AND TAKE TIME, EFFORT, AND COOPERATION TO PROCESS REQUIRED TASKS.**

All patients are presented with certain notices and must sign certain forms. Depending on the course of treatment, some patients may be required to sign additional forms. The following is a summary of the most common forms and notices:

**Notice of Privacy Practices –** This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

**Consent for the Use or Disclosure of Protected Health Information –** The Practice may not use or disclose your health information without your expressed authorization. Your signature on the separate form indicates that you are giving permission for the use and disclosure of your health information for the purpose of treatment, payment, and healthcare operations. You may revoke this authorization at any time by signing and dating a revocation of this form and returning to this office.

**Authorization for Use or Disclosure of Protected Health Information –** The Practice may not use or disclose your health information without your authorization. Your signature on the separate form indicates that you are giving permission to the people listed on the form, for the use and disclosure of the health information listed on the form, for the purposes listed on the form, to the people/organizations listed on the form. You may revoke this authorization at any time by signing and dating a revocation of this form and returning to this office.

**Complaint –** You have the right to complain about the Practice's privacy policies, procedures, or actions. The Practice will not engage in any discriminatory or other retaliatory behavior against you because of a complaint.

**Request to Amend Protected Health Information –** You have a right to request that health information that pertains to you be amended if you believe that it is incorrect or incomplete. The Practice will review your request and either grant your request or explain the reason why it will not be granted. In the event that your request is not granted, you have the right to submit a statement of disagreement that will accompany the information in question for all future disclosures.

**Request to Inspection of Protected Health Information –** You have a right to request the opportunity to inspect and copy health information that pertains to you. The Practice will evaluate your request and will either grant it or explain the reason why the request will not be granted. In the event that your inspection request is not granted, you may request that the decision be reviewed by someone other than the person who originally denied the request.

**Request for Accounting of Disclosures of Protected Health Information –** You have a right to request an accounting of disclosure of health information that pertains to you.

**Confidential Communication Request –** You have a right to request that communication concerning your personal health information be made through confidential channels. The Practice will do its best to accommodate all reasonable requests.

**Designation of Personal Representative –** You have a right to nominate one or more persons to act on your behalf with respect to the protection of health information that pertains to you. By making this request, you are informing the Practice of your wish to designate the named person as your personal representative. You may revoke this designation at any time by signing and dating a revocation of this form and returning it to this office.

**ACKNOWLEDGEMENT: By signing, you acknowledge you have been presented with this Notice of Privacy Policies and that you understand and consent to its contents.**

**Patient/Authorized Representative Signature: _____ Date: _____**