Patient Responsibility & Medical Form

Patient Name _____ Patient DOB _____

Responsible Name if different than patient _____ Vision Insurance Plan _____

Medical Insurance _____

Payment Policy (with or without insurance)

1. The patient is responsible for their charges with this office. "Accepting your insurance" means this office will bill insurance one time for payment. It does not guarantee payment by your insurance. If payment has not been received from insurance after 60 days the patient is expected to pay Spectrum Eye Care in full.
2. **Two Insurances**: you may have both **Vision Insurance** like VSP, EYEMED, TRICARE, SUPERIOR VISION, DAVIS VISION **AND Medical Insurance** like Aetna, Cigna, BCBS, Humana, Medicaid, Medicare, VA, TRICARE, United Health and more. We accept both types of insurance.
3. **Medical Insurance** usually **covers office visits for red eyes, scratches, infections, allergy, cataracts, diabetes, macular degeneration** etc. Medical Insurance involves satisfying deductibles and possibly copays with each visit.
4. Contact Lens Patients with vision insurance are charged their Contact Lens New Fit or Refit fees not covered by their Vision Insurance at the time of the exam.
5. In the unfortunate event the Customer and or Responsible will not pay the full balance of their account the Responsible agrees to pay all reasonable costs of collection and attorney fees. Accounts assigned to collections will be charged an additional $50 collection fee.
6. "I hereby Authorize Release of Information to my insurance company or to any health care professional when necessary for my healthcare or billing."

Signature of Responsible _____ Date _____

Spectrum Eye Care 13530 Norhtgate Estates Dr Ste 200 Colorado Springs, CO 80921

HIPAA Statement

WE RESPECT OUR OBLIGATION TO KEEP HEALTH INFORMATION PRIVATE. We are obligated by law to give you notice of our privacy practices. "I understand Spectrum Eye Care has a notice of privacy practices, which is available for my review if I wish. I acknowledge this notice has been offered."

Choose one

I decline a copy Initials _____ copy of HIPAA Notice of Privacy Practices

I accepted a copy Initials _____ copy of HIPAA Notice of Privacy Practices

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New Patient Medical History OR Please fill out completely your first visit

Established Patient Medical Update Please add new conditions and new medicine. Write "same" if there are no changes.

Sex female male

General Health good improving have not seen a physician recently

My Physician Name _____

Patient History of… circle	Family History of… circle
Allergies (seasonal or sinus)	Cataracts
Cancer	Glaucoma
Elev. Cholesterol / Triglycerides	Macular degeneration
Diabetes or Pre-diabetes	Retinal detachment
High Blood Pressure / Heart Attack	Diabetes
Fibromyalgia	Cancer
Headaches	Arthritis
High Blood Pressure / Heart Attack	Stroke
Thyroid	
Other medical condition	

Patient Eye Health… circle

Wears Glasses	Lasik Surgery	Year _____
Wears Contacts		
Blurry Vision	Cataract Surgery	Year _____
Dry Eyes with Contacts		
Eyes itch, water, burn	Muscle/lazy eye	Year _____
Cataracts Glaucoma		
Floaters Macular degeneration		

Medications

_____

_____

_____

_____

_____

_____

_____

What drug is patient allergic to?

_____