Past and Present Medical History Form

Today's Date ____ / ____ / ____

Patient Name: _____Date of Birth ____ / ____ / ____
Last Name First Name Middle Initial Mo Day Year

Address: _____
Street City State Zip Code

Gender (Please circle): Male Female Transgender

Primary Phone #_____ /_____ Secondary Phone # _____ /_____

SS# _____ Email Address: _____

Employer: _____ Occupation_____

Can we leave voicemails regarding your health information, including test results?
Please check: Yes___ or No____

Are you interested in hearing about our cosmetic specials? Yes___ No___
Are you interested in LASIK? Yes___ No___

Financial Responsible Party (If same as above skip this section)

Name_____ Relationship to patient _____
Last Name First MI

Address: _____
Street City State Zip Code

SS# _____ Employer _____

Work Phone # _____ /_____

I Authorize Centennial Eye And Cosmetic Associates to share my personal information with the following people:

1.)_____ Relationship: _____ Phone #: _____ ☐ Emergency Contact

2.)_____ Relationship: _____ Phone #: _____ ☐ Emergency Contact

3.)_____ Relationship: _____ Phone #: _____ ☐ Emergency Contact

Patient/Authorized Representative or legal Guardian Signature: _____

Accident Information:

Is your visit today a result of an accidental injury? (Please circle) YES or NO?
If you circled "Yes", please circle one of the following: AUTO WORK OTHER:_____
If you answered "Yes" please provide additional information. For Workman's Comp, we will need the name of your company and your employer or supervisor's name.
Contact Person: _____
Claim Number_____

Address_____
Street City State Zip Code

How did you hear about us? Referring Provider ____Third Party ____Our Website ____Other_____
Primary Language: English____ Spanish____ French____ Other _____Declined to answer____
Race: American Indian or Alaska Native ___ Asian___ African American___ Native Hawaiian/Pacific Islander___ White ____ Other____ Declined to answer ____
Ethnicity: Not Hispanic or Latino ____ Hispanic or Latino ____ Declined to answer ____

PRIMARY MEDICAL COVERAGE
Insurance Company _____
Name of Policy holder _____ Relationship to patient _____
ID# _____ Group # _____
Policy Holder's Date of Birth ____ / ____ / ____ Policy Holder's SS# _____
Mo Day Year
Co-pay_____ or Deductible _____

SECONDARY MEDICAL COVERAGE
Insurance Company_____
Name of Policy holder _____Relationship to patient_____
ID# _____ Group # _____
Policy Holder's Date of Birth ____ / ____ / ____ Policy Holder's SS# _____
Mo Day Year
Co-pay_____ or Deductible_____

ROUTINE VISION INSURANCE (VSP, Eyemed, Superior..)
Insurance Company _____
Name of Policy Holder _____Relationship to patient_____
ID# _____ Group # _____
Policy Holder's Date of Birth ____ / ____ / _____ Policy Holder's SS# _____
Mo Day Year
Co-pay_____ or Deductible_____

Authorization

As a member of an insurance plan, I am aware that I am required to bring my insurance card and obtain a referral, if necessary, in order to receive benefits for specialty care from Centennial Eye Associates. If I do not have a valid referral or authorization from my insurance company, I understand I am fully responsible for all charges incurred.

I hereby authorize payment of all benefits to Centennial Eye Associates for services rendered. I authorize the release of any medical information necessary to process this claim and all future claims. I authorize the use of this signature on all insurance submissions.

I agree that I am responsible for all co-payments, deductibles, co-insurance, non-covered services, and amounts exceeding any maximum benefits outlined by my insurance plan. I understand that in the

Past and Present Medical History Form

event my insurance company does not pay for services rendered by Centennial Eye Associates, I agree to accept full financial responsibility for any direct or ancillary charges for services rendered in behalf of myself and/or my dependents.

_____ _____ Today's Date___/___/___
Patient Name (Printed) Patient Signature

Patient First and Last Name *(Printed)***:** _____ **Date of Birth:** __/__/____

Today's Date: __/__/___ PCP: _____ Referring Provider: _____

Providers Phone Number_____

What is the reason for your visit today? _____

Please indicate any and all changes from the LAST visit below.

Past/Current Medical History: *Check all that apply*

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Irregular heartbeat
- ☐ Bone Marrow Transplant
- ☐ Cancer of any kind
- ☐ Heart disease
- ☐ Cardiac arrest
- ☐ Carotid artery occlusion
- ☐ Chronic pain
- ☐ COPD
- ☐ Congestive heart failure
- ☐ Dementia
- ☐ Kidney disease
- ☐ Mental disorder
- ☐ RA
- ☐ Pre-diabetes
- ☐ Depression
- ☐ Diabetes
- ☐ Kidney disease
- ☐ Acid Reflux
- ☐ Hearing loss
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ HIV/AIDS
- ☐ High cholesterol
- ☐ Hyperthyroid
- ☐ Hypothyroid
- ☐ Radiation treatment
- ☐ Seizures
- ☐ Stroke

Medications: *Please list **ALL** medications*

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Past Surgeries: *Please note type and date of each operation below*

_____
_____
_____

***Allergies:** *Please list all allergies*

_____ _____ _____

_____ _____ _____
_____ _____ _____

Eye History: *Please check all that apply and note if right eye, left eye, or both eyes*

- ☐ Pink Eye R/L/B
- ☐ Inflamed eyelids
- ☐ Cataracts R/L/B
- ☐ Contact lenses
- ☐ 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
- ☐ Ocular hypertension R/L/B
- ☐ Ocular migraine
- ☐ Retinal tear R/L/B
- ☐ Strabismus R/L/B
- ☐ Floaters R/L/B
- ☐ Other:_____ _____

Eye Surgery: *Please check all that apply*

- ☐ Blepharoplasty R/L/B
- ☐ Cataract surgery R/L/B
- ☐ Corneal transplant R/L/B
- ☐ Eye injections R/L/B
- ☐ Lasik/PRK R/L/B
- ☐ Laser-narrow angles R/L/B
- ☐ Laser-open angles R/L/B
- ☐ Ptosis repair R/L/B
- ☐ YAG laser R/L/B
- ☐ Punctal plucs R/L/B
- ☐ Retinal laser R/L/B
- ☐ Other:_____ _____

Family History: *Please check all that apply*

- ☐ Blindness
- ☐ Cancer
- ☐ Cataracts
- ☐ Stroke
- ☐ Diabetes
- ☐ Amblyopia
- ☐ Blindness/low vision
- ☐ Strabismus
- ☐ Arthritis
- ☐ docrine disease
- ☐ Hashimotos
- ☐ High cholesterol
- ☐ Glaucoma
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Macular degeneration
- ☐ Migraines
- ☐ Retinal detachmen

Social History:

Do you smoke any of the following? □ Cigars □ Cigarettes □A Pipe □Non-Tobacco User.
Have you ever smoked or used tobacco? _____
If you smoke, how many times per day do you smoke? _____
Do you drink alcohol? □ Yes □ No If yes, how much and how often? _____

Thank you for being or becoming a patient of Centennial Eye and Cosmetic Associates!

ADVANCE NOTICE AGREEMENT

Centennial Eye and Cosmetic Associates requires a ***24 hour advance notice*** for all cancelled or rescheduled appointments. Without the proper notice, you will be charged a "No Show" fee of **$30.**

I _____, agree that I am financially responsible for any charges

Please print your **first and last name** *above*

I may accrue from missed appointment's in which I did not give proper notice. We will be unable to see any patient who may choose not to sign our Advance Notice Agreement. *Exceptions to this rule and the financial responsibility for missed or late appointments, (such as an ocular emergency or other unforeseen emergencies) will be taken into consideration and reviewed on a case by case basis.*

_____ _____

Print Patient Name Date

_____ _____

Patient or Legal Guardian Signature Relationship (*if not Patient)*

FINANCIAL POLICIES

General Policy

Our policy is to bill insurance claims as a courtesy to our patients. In order to bill your insurance claims, we need current insurance information at each visit and for you to understand the terms, conditions and limitations of your policy, including exclusion periods for certain illness and procedures, waiting periods and others. We accept payment from insurance companies ("assignment of benefits"), but insurance companies require that you pay your portion, according to the terms of your plan, including co-payments, coinsurance and deductibles.

Our billing department will make every reasonable effort to obtain a timely response from your insurance company. Any insurance claim not paid in a timely manner by your insurance company may become your responsibility. Furthermore, health insurance is a contract between the insurance company and you *(the patient).* That being said, the responsibility of payment for the services rendered belongs with the patient. Credit balances will be applied to future services unless a refund is requested.

Payments Due at Time of Service:

We will collect the following payments at the time of service:

Co-Pays **Co-Insurance** **Contact Lens Fittings** **Refractions**
Previous Balances **Deductibles** **Non-Covered Services**

Although these charges are normally collected at checkout, we may ask you to confirm your ability to pay when you check in. If you are unable to pay for the services we provide, we may reschedule your appointment.

Check Acceptance Policy

Centennial Eye Associates tries to make paying your bill as effortless as possible. We do accept personal checks for payment, however, checks may be subject to all penalties under the Colorado Returned Check Law: CRS 13-21-109. For additional information about this, please call (303) 886-5304 or visit www.ago.state.co.us/cab/colltp/badcheck.htm. We reserve the right to report bad checks to the State District Attorney's Office. Our returned-check fee is $30.00 and the loss of accepting checks as payment in the future.

Statement Charge, Late Fees & Collections

Due to increasing postage and paper costs, we will assess a statement fee of $1.00 for each statement we mail to our patients. If an account becomes delinquent (more than 30 days old, aged from the date of service), we may assess a late fee. Should an account be unpaid after 90 days, we may turn the account over to an outside collection agency. There is a $25.00 collection service fee added to all collection status accounts.

Optical Department Purchases

Due to the highly customized nature of eyeglasses and the unique prescription in them, ***we cannot offer refunds on purchases****.* **All purchases of eyeglasses are final.** *We are happy to adjust your prescription if necessary. Any changes to prescription eyeglasses must be made within 90 days of the original purchase.*

I have read, understand and agree to the Financial Policies outlined above. Unless under emergency Circumstances we will be unable to see any patient who refuses to sign this Financial Policy.

_____ _____

Patient Name (print clearly) Date

_____ _____

Patient Signature Date

CEA PATIENT HIPPA AKNOWLEDGMENT AND PATIENT INFORMATION RELEASE

My signature below confirms that I have been informed that all Centennial Eye and Cosmetic Associates employees, appointees and assigns are operating in compliance with the Health Insurance Portability and Accountability Act (HIPPA Privacy Act). I understand that the goal of the HIPPA Privacy Act is to **protect** my personal information and treatment from being observed by another patient or unauthorized persons and used for solicitations or purposes other than those associated with eye care at this facility.

In keeping with the effect to maintain and protect my privacy. I hereby authorize Centennial Eye and Cosmetic Associates Employees, appointees and assigns to contact me via postcard and postal services or to leave me voicemails and text messages on my work, home or cell phone, as provided, to remind me of regular check-ups, to confirm appointments, to request a follow up visit or to notify me of any special programs offered from this facility.

You may also use electronic means such as email, for the above purposes and my email address is _____.

Today's Date: __/__/____ Please print your first and last name:_____

Signature: _____

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review the following information carefully.

Your health information contains personal information about you and your health and is referred to as Protected Health Information ("PHI"). This information contains details that can be used to identify you and any information we have created or received regarding your past, present, or future conditions. This Notice describes how we may use and disclose your PHI in accordance with applicable law.

We are legally required to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of this notice at any time. Any changes to this notice will be effective for all PHI we have at that time. The new Privacy Practices will be available upon request.

How We May Use And Disclose Your PHI

- **For Treatment:** Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordination, or managing your health care treatment and related services.
- **For Payment:** We may use and disclose PHI so that we can receive payment for the treatment services provided to you.
- **For Health Care Operation:** We may use or disclose your PHI for our health care operations. This might include measuring quality of care, licenses and/or certifications to continue providing quality care.
- **Required by Law:** We may disclose your PHI when required by law without your approval. Examples of when this may happen include abuse, neglect, domestic violence, emergencies, judicial or administrative proceeding, public safety risk, etc.

Your Rights Regarding Your PHI

You have the following rights regarding PHI we maintain about you. Please submit your request in writing to Centennial Eye and Cosmetic Associates, 15901 E Briarwood Cir #100, Aurora, CO 80016 or send it by fax: (303)699-3170.

- **Right to Request Limits on Uses and Disclosure.** You have the right to request how we use and disclose your PHI. Uses and disclose where legally required to make can not be limited. However you may submit your request for review.
- **Right to of Access and Receive Copies.** You have the right, in most cases to review and receive copies of your PHI. A request must be submitted in writing to Centennial Eye and Cosmetic Associates, 15901 E Briarwood Cir #100, Aurora, CO 80016 or sent by fax: (303)699-3170. You may be charged a fee for copies made.

- **Right to Amend.** If you feel your PHI is incorrect or incomplete, you may request your PHI be amended. You must request in writing the what is to be amended and why at Centennial Eye and Cosmetic Associates, 15901 E Briarwood Cir #100, Aurora, CO 80016 or fax: (303)699-3170.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you in a certain way or at a certain location.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS:

If you feel your rights have been violated, you have the right to file a complaint with out retaliation. Please submit your complaint in writing to our Director at Centennial Eye and Cosmetic Associates, 15901 E Briarwood Cir #100, Aurora, CO 80016 or fax: (303)699-3170. Complaints can also be filed online at http://www.hhs.gov/ocr/privacy/index.html.

I have read and understand the above Notice of Privacy Practices for Centennial Eye and Cosmetic Associates. I understand I have the right to ask questions about this information at any time.

_____ _____

Signature of Patient or Legally Responsible Party Date

_____

Name (please print)

KNOW THE DIFFERNCE
"ROUTINE VISION EXAM" vs. "MEDICAL EXAM"

Most **routine vision** insurance plans do ***not*** pay for medical exams, and many **medical** insurance plans do not cover routine vision exams. Therefore, it is important to know the difference.

A **routine vision exam** using an insurance plan **(**such as VSP, EyeMed, or A vision care plan) is acceptable if you have no medical complaints or past history of ocular disease. However, if you come in to see the eye doctor and you are experiencing symptoms or complaints of an eye problem, or have a diagnosis of an ocular condition and or disease, this may no longer be considered a routine vision exam. Instead, it is regarded as a medical exam.

In a **medical exam**, your doctor may spend extra time reviewing details of the problem and diagnosis of your eye condition. The doctor may also want to do additional testing to further evaluate your eye condition. *Pre-existing ocular conditions or diseases may include but are not limited to: diabetes, cataracts, macular degeneration, high myopia, corneal dystrophies, glaucoma, ect..*

If your exam is a medical exam, your insurance company may then require a separate copayment, a higher deductible or out-of-pocket expenses, and or a referral from your primary care physician in accordance with the terms of your insurance plan benefit. We will always try to assist you in determining what benefits you may be eligible for. However ultimately, it is the patient's responsibility to determine this. Depending on the outcome of your exam, your insurance plan(s) may require us to bill the exam in a way that is contrary to your wishes.

Our mission is to provide the best state-of-the-art, high-quality, and educational eye care available in a friendly, "no-wait" atmosphere. If you have any questions regarding your insurance coverage, please contact the Member Services number listed on your insurance card. Any credit balances on your account will be applied to future services unless a refund is requested.

Initials: ____

Centennial Eye & Cosmetic Associates

CONTACT LENS EVALUATION

Thank you for choosing Centennial Eye Associates for your eye care needs. We strive to provide all contact lens wearers with a contact lens that will provide great comfort and clear vision. In order to do this a contact lens evaluation must be performed ***every* year**. Contact lens patients require additional testing and monitoring over and above what is done during a routine eye exam. This includes evaluating the health of the eyes paying close attention to the cornea, eyelids, and conjunctiva, determining the appropriate contact lens prescription and curvature, and examining the lenses on the eyes to ensure proper alignment with the cornea and eyelids. Most vision plans view contact lenses as elective vision correction and generally offer a discount toward the contact lens evaluation fee. Fees are determined by the type of lens, complexity of the prescription, and overall eye health.

Level 1: $70 Spherical contact lenses.

Level 2: $100 Astigmatism corrective contact lenses.

Level 3: $150 Multi-focal/Bifocal , SV Duette and Gas Permeable contact lenses.

Level 4: $200 Bifocal-Toric, Duette Progressive and Bifocal Gas Permeable contact lenses.

Level 5: $600 Scleral and Other Specialty Contact lenses (May be covered by insurance).

THIS ALSO INCLUDES:

- Contact lens case and sample of solution
- Trial contact lenses
- 90 days of follow-up care (there is a follow-up fee of $30 once outside of 90 days)

PLEASE CHECK BELOW

_____ YES… I would like a contact lens evaluation today in order to update my contact lens prescription and have the ability to purchase contacts for the next 12 months. I understand that the fitting must be paid at the time of service.

_____ NO… I do not want a contact lens evaluation today and I understand that I will not be able to purchase contacts without an updated contact lens prescription.

Patient Name:_____

Patient Signature _____ Today's Date __/__/____

If you have any questions, please do not hesitate to ask!