Date: _____ Legal Name: _____

PINE CREEK VISION CLINIC

Nickname: _____Date of Birth: ____/____/____ Sex: _____SSN: _____

Street Address: _____ City: _____ State: ____ Zip Code: _____

Email: _____Primary Phone #: _____Secondary #: _____

Optomap ($39) OR **Dilation** (Please circle one)

Preferred Language: ☐ English or ☐ Other ☐ Decline to Answer

Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Caucasian ☐ Native Hawaiian or other Pacific Islander ☐ Other ☐ Decline to Answer

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Answer

Reason for Today's Visit: _____

Spouse or Parent's Name and Phone number: _____

May we speak to them in regard to your medical and billing information: _____

Employer or School: _____ Occupation or Grade: _____

Referred by: _____

Patient Medical History

Date of Last Eye Exam: _____ Do you wear contact lenses? _____ Do you wear glasses? _____

Do you use eye drops? _____ What kind? _____ Any concerns? _____

Primary Care Physician: _____ Number: _____

Preferred Pharmacy: _____ Number: _____

☐ Cardiac	☐ Blood Pressure	☐ Cataract	☐ Use Alcohol
☐ Diabetes	☐ Glaucoma	☐ Flashes or Floaters	☐ Concussion / TBI
☐ Respiratory	☐ Macular Degeneration	☐ Dry Eye	☐ Stroke
☐ Endocrine(Thyroid)	☐ Diabetic Retinopathy	☐ Use Tobacco	☐ Headaches/Migraines

Any medical conditions we should be aware of that is not listed? _____

Medication Allergies: _____

Current Medications or Drops: _____

_____

Insurance Information: The eye health portion of your examination may be billable to your medical insurance even if you do not have vision coverage.

Vision Insurance: _____

Subscriber's Name: _____

Subscriber's Date of Birth: _____

Subscriber's SSN: _____

ID#: _____

Group#:_____

Employer: _____

Medical Insurance: _____

Subscriber's Name: _____

Subscriber's Date of Birth: _____

Subscriber's SSN: _____

ID#: _____

Group#:_____

Employer: _____

MEDICAL INSURANCE- The eye health portion of your examination may be billable to your medical insurance even if you do not have vision coverage.

Payment Policy: **Payment is required when services are rendered, or materials are ordered**. Quotes of insurance coverage are based on information from the insurance company and are not guaranteed. Although we will gladly bill insurance for you, patients remain responsible for their charges even after insurance has been billed. If payment has not been received from insurance after 60 days, the patient will be expected to pay Pine Creek Vision Clinic.

"I understand that I am personally responsible for payment of my account even if I have insurance. If it becomes necessary to use a collection agency for any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses including reasonable attorney's fees. Accounts assigned to collections will be charged a $50 collection fee."

Signed: _____ **Date**: _____

"I hereby authorize release of information to my insurance company or to any health care professional or educational professional when necessary for my healthcare or billing." (This allows us to bill your insurance.)

Signed: _____ **Date**: _____

Dr. Thomas A. Wilson O.D. Pine Creek Vision Clinic Colorado Springs, CO

ACKNOWLEDGEMENT OF RECEIPT OF SUMMARY NOTICE OF PRIVACY PRACTICES

Revised April 19, 2017

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains participant rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office at (719) 594-2020.

You have the right to request that we restrict how protected information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke the Consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. Dr. Thomas A. Wilson O.D. Pine Creek Vision Center Colorado Springs, CO provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The participant understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- Dr. Thomas A. Wilson O.D. Pine Creek Vision Center Colorado Springs, CO has a Notice of Privacy Practices and that the participant has the opportunity to review thisnotice.
- Dr. Thomas A. Wilson O.D. Pine Creek Vision Center Colorado Springs, CO reserves the right to change the Notice of Privacy Practices.
- The participant has the right to request restrictions to the uses of their information but Dr. Thomas A. Wilson O.D. Pine Creek Vision Center Colorado Springs, CO will not have to agree to those restrictions.
- The participant may revoke this Consent in writing at any time and full disclosures will then cease.
- Dr. Thomas A. Wilson O.D. Pine Creek Vision Center Colorado Springs, CO may condition receipt of treatment upon the execution of thisconsent.

I have received a copy of the Summary Notice of Privacy Practices. I understand that I may also request a copy of the practice's complete Notice of Privacy Practices if I so desire.

Signed: _____ **Date**: _____