PREMIER VISION
Compassionate Eyecare

Name: Title_____ First_____ Last_____ MI_____ Suffix _____Nickname_____

Address: _____ City_____ State_____ Zip _____

Billing Address (if different) _____City_____ State_____ Zip _____

Date of Birth _____ SSN_____ Sex: M / F / X Marital Status _____

Employment Status _____ Employer Name_____ Occupation _____

Home Phone_____ Mobile Phone_____ Work Phone_____

Email_____ Preferred Contact Method (circle one): Home Mobile Work Email Other

Whom may we thank for referring you to Premier Vision? _____

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Medical Insurance Name: _____ Insurance Plan_____

Insurance ID_____ Insurance Policy Group ID _____

Relationship to Insured: Self / Spouse / Child / Other

Insured Name: _____ DOB_____ SSN_____ Employer _____

Insured Address (if different) _____City_____ State_____ Zip _____

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Secondary Medical Insurance Name: _____ Insurance Plan_____

Insurance ID_____ Insurance Policy Group ID _____

Relationship to Insured: Self / Spouse / Child / Other

Insured Name: _____ DOB_____ SSN_____ Employer _____

Insured Address (if different) _____City_____ State_____ Zip _____

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Vision Insurance Name: _____ Insurance Plan_____

Insurance ID_____ Insurance Policy Group ID _____

Relationship to Insured: Self / Spouse / Child / Other

Insured Name: _____ DOB_____ SSN_____ Employer _____

Insured Address (if different) _____City_____ State_____ Zip _____

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Original: Patient Signature: _____ Date: _____

Update #1 Patient Signature: _____ Date: _____

Update #2 Patient Signature: _____ Date: _____

Update #3 Patient Signature: _____ Date: _____

Medical History:

How may we care for you today? _____

Current Medications: (Rx, OTC and herbal) _____

Allergies_____ Reaction _____

Do you have back-up glasses? Y / N Do you have sunglasses? Y / N Do you have Rx sunglasses? Y / N

Do you want new glasses? Y / N Do you wear contacts? Y / N If no, are you interested in contacts? Y / N

What type/brand to you wear? _____ Average hours worn per day___ How old are they? _____

Do you have RX sunglasses? Y / N Considering laser surgery? Y / N Time on Electronics per day _____

Date of last eye exam: _____ Doctor/Location: _____

Date of last physical exam: _____ Doctor/Location: _____

Are you experiencing any of the following? (Circle all that apply)

Dry Eyes	Lazy/Crossed	Double Vision	Eye Disease	Cataracts	Glare from lights at night
Burning	Tearing	Itching Eyes	Glaucoma	Floaters	Flashes of light
Red Eyes	Eye injury	Eye Surgery	Headaches	Retinal Disorders	

If you answered yes to Headaches (above) please answer these questions: How often _____ Location_____

Duration _____ Do you wake up with them? Y / N Severity _____ Onset time of day: AM / PM

How do you get relief? _____

Family Eye History, (Circle all that apply to your Parents, Siblings, Grandparents):

Macular Degeneration	Glaucoma	Retinal Detachment	Cataracts	Lazy/Crossed Eyes	Blindness

Do you or anyone in your family have any of the following medical conditions?

Diabetes	Y / N	Year diagnosed _____	Please describe: _____
High Blood Pressure	Y / N	Year diagnosed _____	Please describe: _____
High Cholesterol	Y / N	Year diagnosed _____	Please describe: _____
Thyroid Conditions	Y / N	Year diagnosed _____	Please describe: _____
Heart Conditions	Y / N	Year diagnosed _____	Please describe: _____
Cancer	Y / N	Year diagnosed _____	Please describe: _____

Smoker? Y / N / Previous Alcohol Use? Y / N / Occasionally Illegal Drug use? Y / N / Previous

Hobbies_____

Anything additional you'd like us to know? _____

Original: Patient Signature: _____ Date: _____

Update #1 Patient Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003 and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. In the event we make a material change in our privacy practices, we will change this Notice and provide it to you. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:
Treatment: We may use or disclose your health information to an optician, ophthalmologist or other healthcare provider providing treatment to you for: a) the provision, coordination, or management of health care and related services by health care providers; (b) consultation between health care providers relating to a patient; (c) the referral of a patient for health care from one health care provider to another; or (d) recall information.
Payment*:* We may use and disclose your health information to obtain payment for services we provide to you. This may include: (a) billing and collection activities and related data processing; (b) actions by a health plan or insurer to obtain premiums or to determine or fulfill its responsibilities for coverage and provision of benefits under its health plan or insurance agreement, determinations of eligibility or coverage, adjudication or subrogation of health benefit claims; (c) medical necessity and appropriateness of care reviews, utilization review activities; and (d) disclosure to consumer reporting agencies of information relating to collection of premiums or reimbursement.
Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include things such as quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.
Your Authorization**:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.
Marketing Health Products or Services: We will not use your health information for marketing communications without your prior written authorization. We may provide you with information regarding products or services that we offer related to your health care needs. We will never sell your health information without your prior authorization.
To You, Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so or, if you are not able to agree, if it is necessary in our professional judgment.
Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical

supplies, x-rays, or other similar forms of health information.

Required by Law: We may use or disclose your health information when we are required to do so by law, including judicial and administrative proceedings.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal official's health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders and Treatment Alternatives: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters) or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

PATIENT RIGHTS

Access: You have the right to review or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations, where you have provided an authorization and certain other activities, for the last 6 years, but not for disclosure made prior to April14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request in writing that we communicate with you about your health information by alternative means or to alternative locations. Your request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Premier Vision Contact Person: Raé M. Cody, Practice Administrator, E-mail: RaeC@premiervision.com
Telephone: 719-488-9595 Fax: 719-488-8383, Address: 1180 Village Ridge Pt., Monument, CO 80132

Please sign and date that you have read and agree to our Notice of Privacy Practices Policy, thank you!

Patient Signature: _____ Date: _____

PREMIER VISION FINANCIAL POLICIES

Thank you for choosing Premier Vision for your vision and eye care needs. Our goal is to make you feel welcome and important as we serve you with the best care possible by demonstrating a commitment to provide thorough, state of the art, ocular services and eyewear products. We use the latest technology and diagnostic equipment and offer the newest options in ophthalmic lenses for both glasses and contacts. Our dispensary is stocked with over 900 frames in all price ranges. Premier Vision doctors provide treatment and management of eye disease and injuries in addition to pre- and post-operative care for both laser refractive surgery and cataract surgery. We are also available on a "same day" basis for acute ocular conditions including: injuries, infections, sudden vision change or loss. One of our doctors is on call during non-office hours should the above situations arise.

Insurance

Premier Vision doctors are providers for numerous medical and vision insurance panels. We are happy to file your insurance claims. Your responsibility will be for any co-payment and other charges your insurance does not cover. Our office will help you receive your maximum benefits, if you have provided us with the necessary current insurance information at the time of examination, or before the time your eyewear is ordered. Otherwise, you will be responsible for all costs incurred. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, coverage, etc. If your insurance company has not paid the balance within 60 days of service, and it is determined that they will not be paying, you will have 30 days to pay the balance. Should the account be referred for collections, you will be responsible for collection fees and expenses.

If Premier Vision is not contracted with your insurance provider, you will be responsible for all fees and charges that you incur. Payment is due the day of the examination unless prior arrangements have been made. Our office will provide you with an itemized statement that you can submit to your insurance company for reimbursement.

As a patient you are entitled to a copy of your clinical findings (the original examination document).

A clinical summary is often easy to review and understand. We are happy to provide you with a clinical summary after your appointment. This summary contains a list of diagnosis your doctor assigns and an explanation of each diagnosis. We will provide this to you at your request within 48 hours of your examination.

Payment

We accept cash, check, Visa, MasterCard, Discover and CareCredit. A $30.00 returned check fee will be assessed for any returned checks.

50% down payment is required to order glasses or contact lenses, the balance is due when they are dispensed.

Insurance Co-payments

If your insurance plan requires a co-payment, you are expected to pay this at the time of service.

Uninsured Patients

If you do not have insurance for services provided, a 20% administrative discount will be given if the account is paid in full on the day of service. This applies to services only; glasses, contacts and other eyewear are not included.

Refunds and Small Balances

In an effort to limit trivial transactions between the practice and our patients, in general, if your balance is less than $5.00, we will write off that balance and not bill you for it. Likewise, if we owe you less than $5.00, unless you specifically request otherwise, we will write off these small balances.

Refunds are made after all insurance claims have been settled. If a refund is due, in general, you can anticipate receiving the refund within two weeks of our learning that a refund is due.

Collections

Accounts with services over 60 days old are considered "Past Due." Our billing staff will make a reasonable attempt to notify you if your account has reached a "Past Due" status. It is important that all changes in your name, address, phone number, insurance, or employment be relayed to our office as it can affect the billing of your account. If we are unable to locate a patient, payment is not received, or satisfactory payment arrangements are not made, then an account will be referred to our collection agency. Should this occur the patient will be responsible for collection fees and expenses.

Lack of Cooperation

We are grateful for all our patients and the opportunity to serve them. We appreciate your assistance in helping us complete our work in an efficient and accurate manner. We believe that all patients should be treated with dignity. We reserve the right to terminate a patient from the practice in those rare cases when a patient may be verbally or physically abusive, refuse to give necessary information, or is non-compliant with ocular instructions, treatment and advice.

Please sign and date that you have read and agree to our Financial Policies, thank you!

Patient Signature: _____ Date: _____

Premier Vision Dilation and/or Retinal Photography Consent Form

What is dilation?

Dilation involves instilling eye drops to enlarge the pupils to allow a more thorough assessment of the retina. Dilation is an integral part of a complete eye exam. Dilation will make your pupil (the center of your eye) larger allowing the doctor to check for any problems such as (but not limited to):

Systemic Diseases:	Diabetes	High Blood Pressure	Cancer	
Physical Changes:	Cataracts	Glaucoma	Macular Degeneration	Retinal detachment

Do I need dilation?

It is highly recommended to have your eyes dilated if you are and/or have:

New to our office	Diabetic or high blood pressure
Over age of 45	Eye prescription over -6.00
Medical condition requiring yearly monitoring	Flashing Light / Recent new floaters
Eye pain and/or sudden loss of vision	Never been or 1+ years since dilated

Possible Side Effects

Effects normally last for 3-6 hours, but it can last longer. Difficulty reading things up close with increased light and glare. While dilated, we recommend sunglasses with adequate UV protection. You may use personal sunglasses, or we will provide you with temporary sunglasses.

Operation of vehicles & equipment: most people will be able to operate them, however, if you feel uncomfortable operating them, or have never had your eyes dilated, it may be best to have someone else operate them or wait until effects have passed.

_____ Yes, I understand the common side effects of dilation and consent to having my eyes dilated.

_____ No, I understand and have been fully informed of reasons dilation is recommended but decline dilation.

Alternative to Dilation

Retinal photography (OptoMap) is a procedure that uses digital photography to document the important anatomical structures of the back of the eye (the retina) without the use and side effects of dilating drops.

This instrument provides important diagnostic information for the doctor and ensures optimal eye care treatment. We will share the photographs and the results with you during your exam. They will become a part of your medical record. If done yearly, this will allow the doctor to form a baseline and track any changes.

NOTE: *There is an additional fee for retinal photography, and it is not a complete substitute for dilation.*

These digital photos assist us in the early detection of glaucoma, macular degeneration, diabetic changes and other retina diseases. This permanent record is very valuable in assessing the current health of your eyes and will serve as a baseline from which to compare, as we follow your health in subsequent years. The screening fee is not covered by insurance and is $39.

_____ Yes, I consent to Retinal Imaging (Optomap) and payment of $39.

_____ No, I do not consent to Retinal Imaging and understand I will be dilated today or scheduled at a later date.

Patient Signature: _____ Date: _____