

HAAS VISION CENTER  
Patient Registration Form

Name: \_\_\_\_\_  
Last First Middle

Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone No: \_\_\_\_\_ Cell No: \_\_\_\_\_ Other No. \_\_\_\_\_

Email: \_\_\_\_\_ Ok to contact by email? YES NO

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Employer: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Emergency Contact (please list name, phone number and relationship): \_\_\_\_\_  
\_\_\_\_\_

Who will be guaranteeing payment for today's visit? Please list name, address, telephone number and relationship if the patient is not the guarantor. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Primary Insurance: \_\_\_\_\_ Policy Owner: \_\_\_\_\_  
Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Policy Owner: \_\_\_\_\_  
Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Is the patient a minor? YES NO Does the patient have a legal representative? YES NO  
If yes to either, please list name, address and phone number of legal representative.  
\_\_\_\_\_  
\_\_\_\_\_

Is there anyone we can talk to regarding your protected health information? Yes \_\_\_ No \_\_\_

By signing here, I authorize Haas Vision Center to use and/or disclose certain protected health information to: \_\_\_\_\_

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_

I have the right to revoke this authorization in writing except to the extent that Haas Vision Center has relied on this authorization.

1. I authorize Haas Vision Center to release any information regarding my examination and/or treatment to any other physician, insurance company or health organization as required.
2. I authorize any physician, hospital or medical care facility to provide all information regarding my health history and/or treatment to Haas Vision Center.
3. I authorize payment directly to Haas Vision Center for the surgical and/or medical benefits, if any, otherwise payable to me under the terms of my insurance.
4. I understand that I am ultimately responsible for payment for services rendered even though it may be covered by medical insurance, Workers Compensation, or a private agreement with another party.

Patient/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Haas Vision Center would appreciate if you took the time to let us know how you heard about us.

*Please circle all that apply.*

Yellowbook Yellow Pages Yellowpages.com

Dex Yellow Pages (or Dex Online) Google

Colorado Springs Gazette Yahoo

The Tribune Bing

Pikes Peak Courier View Radio

TV

Other: \_\_\_\_\_

Referred by physician: \_\_\_\_\_

Referred by optometrist: \_\_\_\_\_

Referred by family/friend: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_

**HAAS VISION CENTER FINANCIAL POLICY**

Haas Vision Center is a dedicated medical and surgical practice. Therefore, we do not accept any vision plan insurance. Your exam today WILL be billed under your medical insurance. Please understand that vision insurance will only cover routine vision problems such as near or far-sighted vision, eyeglasses and contacts; vision insurance will not cover medical eye conditions.

Please understand that our financial policies are established to assure the financial resources needed to maintain this medical office for all our patients. We will work with you regarding your financial responsibility.

- We must emphasize that as a health care provider our relationship is with you, not your insurance company.
- Your insurance is a contract between you, your employer, and the insurance company. We bill your insurance company as a courtesy to you, the patient.
- You are responsible for knowing what your co-payments, deductibles and/or co-insurance is with your insurance provider. Please contact your insurance company and/or your employer’s human resources department with regards to your benefit questions.

If you have health insurance with which we participate:

- We will bill your insurance claim for you.
- We expect any required co-payment at time of service.
- We expect payment of the deductible and coinsurance to be paid in full after we have issued you a statement to be paid within 30 days unless prior arrangements have been made.

If you are uninsured or we do not participate with your insurance, payment for total charges are due on the day of your appointment unless prior arrangements have been made.

**I have read and accept the terms of this financial policy:**

\_\_\_\_\_  
Patient signature (or person authorized to sign for patient)      Date     /    /

PATIENT NAME: \_\_\_\_\_

**HAAS VISION CENTER**

**INFORMATION AND CONSENT FOR REFRACTION**

It may be important to your care to perform a vision test called a “refraction” to check for your BEST vision. A refraction is when the examiner determines the prescription required for the patient’s eyeglasses by evaluating the effectiveness of a series of lenses through which the patient is asked to view an eye chart. This is accomplished with a phoropter (refractor), a device that contains a range of lens powers that can be quickly changed, allowing the patient to compare various combinations when viewing the eye chart. A lens prescription is issued when the examination is complete.

Medicare, AARP and Medicare Advantage Plans DO NOT COVER refractions. If Medicare does not cover the refraction, neither will most other secondary insurances. The cost for your refraction is \$35.00 which will be collected at check-out today.

Some private insurance plans will cover the cost of refractions. Therefore, we will bill your private insurance for the refraction. If the private insurance denies the refraction, we will send you a statement for the cost of the refraction (\$35.00).

**I understand Haas Vision Center’s policy regarding refractions and that *if* I have a refraction the cost of the refraction will be as stated above.**

\_\_\_\_\_  
Patient signature (or person authorized to sign for patient)          /    /      
Today’s Date

PATIENT NAME: \_\_\_\_\_

**HAAS VISION CENTER**

**INFORMATION AND CONSENT FOR DILATED EYE EXAMINATION**

It may be important to your care today to dilate your eyes. Dilating eye drops are used to enlarge the pupils of the eye to allow the physician to obtain a better view of the inside of your eyes.

Dilation frequently changes vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for us to predict to what degree your vision will be affected. Driving may be difficult immediately after the examination. If you are concerned about these problems, you may wish to make alternative transportation arrangements, although a large number of patients do drive after dilation with the assistance of temporary sunglasses, which we can provide after your dilation.

Adverse reactions, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize the physician and/or such assistants as may be designed by him to administer dilating eye drops. The eye drops are necessary to perform a complete exam of the retina and the back of the eye. This may reveal the presence of a serious systemic condition as well as eye conditions.

**I agree to have the dilation examination on every visit that Dr. Haas deems it necessary to conduct a complete examination of my eyes. I understand that if I decide not to have the dilated examination, I must sign another form revoking my consent for that visit only.**

\_\_\_\_\_  
Patient Signature (or person authorized to sign for the patient)

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

HAAS VISION CENTER

RECEIPT OF NOTICE OF PRIVACY PRACTICES  
WRITTEN ACKNOWLEDGMENT FORM

I, \_\_\_\_\_, have read /received a copy of the Notice of Privacy Practices.

Signature of Patient: \_\_\_\_\_

Date: \_\_\_\_\_

Signature of Guardian: \_\_\_\_\_

Date: \_\_\_\_\_