



6385 Corporate Drive, Suite 307
Colorado Springs, CO 80919
Phone 719-272-4227 Fax 719-272-3834

PATIENT REGISTRATION FORM

Name: _____
Last First Middle

What name do you want to be called by? _____

Address: _____

City: _____ State: _____ ZIP _____

Phone No: _____ Cell No: _____ Other No. _____

Email: _____ Ok to contact by email? YES NO

Date of Birth: _____ Social Security Number: _____

Male _____ Female _____

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.

HAAS VISION CENTER

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 |
| KOAA.Com | Yahoo |
| Facebook | Bing |
| Twitter | |

Other: _____

Referred by physician: _____

Referred by optometrist: _____

Referred by family/friend: _____

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.

Haas Vision Center makes every effort to ensure that we participate with your health insurance. Health insurance companies are continually offering new plans with different networks. Unfortunately, the insurance companies do not always let us know if we are in network; therefore, it is impossible to know for certain that we participate with your insurance. It is the patient's responsibility to ensure we are in network before being seen by Dr. Haas. If your insurance claim comes back as out of network, you will be responsible for all charges as dictated by your insurance company.

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.

Late Cancellation/No Show Policy

Due to the increased demand for appointment times, it has become necessary to implement a late cancellation/no show policy for office visits. 24 HOUR NOTICE IS REQUIRED FOR ALL CANCELLATIONS. If a patient appointment has been confirmed and the patient fails to keep the appointment, it will be documented in the patient chart and a fee of \$35.00 will be assessed to the patient's account.

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 \$50.00 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 (\$50.00).

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 designated 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



HIPAA RELEASE OF INFORMATION FORM

Name: _____ DOB: ____ / ____ / ____

Release of Information

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

Spouse _____

Child (ren) _____

Other _____

Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

Signed: _____ Date: ____ / ____ / ____

**RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGMENT FORM**

I, _____, have read /received/been presented with a copy of the Notice of Privacy Practices.

Signature of Patient: _____

Date: _____

Signature of Guardian: _____

Date: _____



Do you currently wear Glasses or Contacts?	YES	NO	BOTH
Have you ever had any eye surgery?	YES	NO	
Have you had Lasik?	YES	NO	

Do you OR any one in your family have any history of the following:

Glaucoma:

Age Related Macular Degeneration:

Retinal Detachment:

Cataracts:

Dry Eyes:

Please mark any condition you have presently or have had in the past:

	YES	NO
HIGH BLOOD PRESSURE		
HEART DISEASE		
RESPIRATORY ISSUES		
ARTHRITIS		
STROKES		
DIABETES		
THYROID		
HIGH CHOLESTEROL		
CANCER		
OTHER:		



FAMILY HISTORY:

	YES	NO	FAMILY MEMBER
HIGH BLOOD PRESSURE			
HEART DISEASE			
RESPIRATORY ISSUES			
ARTHRITIS			
STROKES			
DIABETES			
THYROID			
HIGH CHOLESTEROL			
CANCER			
OTHER:			

Have you ever had any surgical procedures before? _____ If Yes, please list procedures and dates.

_____	_____
_____	_____
_____	_____

Do you receive an Flu Vaccine every year? YES NO

Have you had a Pneumonia Vaccine? YES NO



Please list ALL medications (including non prescription) you are currently taking:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please list all known drug allergies: (If none, please circle None) - NONE

DRUG:

REACTION:

_____	_____
_____	_____
_____	_____
_____	_____

Are you or have you ever been a smoker? YES NO FORMER

Do you drink alcohol? _____ (If yes, how often?) _____



Visual Function Questionnaire

Please Check All That Apply to You

Patient Name: _____

Have you been bothered by:

- | | |
|--|--|
| <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Seeing in poor or dim light |
| <input type="checkbox"/> Hazy vision | <input type="checkbox"/> Halos |
| <input type="checkbox"/> Glare | <input type="checkbox"/> Seeing rings or stars around lights |
| <input type="checkbox"/> Poor night vision | <input type="checkbox"/> Frequent changes in glasses |

Have you noticed difficulty with your vision when you:

- | | |
|--|---|
| <input type="checkbox"/> Work at your job | <input type="checkbox"/> Shop for groceries |
| <input type="checkbox"/> Manage your home | <input type="checkbox"/> Drive during daylight hours |
| <input type="checkbox"/> Get around in your home | <input type="checkbox"/> Drive during evening/night hours |
| <input type="checkbox"/> Watch TV | <input type="checkbox"/> See traffic signs |
| <input type="checkbox"/> Use a computer | <input type="checkbox"/> Sew or do crafts |
| <input type="checkbox"/> Read newspapers | <input type="checkbox"/> Play golf |
| <input type="checkbox"/> Read the telephone book | <input type="checkbox"/> Enjoy recreation or leisure |
| <input type="checkbox"/> Read labels | <input type="checkbox"/> Recognize people |
| <input type="checkbox"/> Read price tags | <input type="checkbox"/> Other _____ |

Patient signature: _____

Date: _____

Reviewed by: _____



Vision Lifestyle Survey

Patient Name _____ DOB _____

We want to help you maintain excellent vision. We will be evaluating you soon for cataracts. The term "cataracts" refers to a cloudy lens within the eye. When a cataract is removed, a lens implant is used to replace the cloudy natural lens. If it is determined that a lens implant is appropriate for you, your answers below will help in determining which implant best suits the demands of your lifestyle. Please fill this form out completely and bring it with you to your evaluation.

1. If lens replacement is recommended for you, Please rate your vision preferences at the Following distances:

Distance Vision: driving, golf, tennis, other

Sports, watching TV

- Prefer no distance glasses
- I wouldn't mind wearing glasses for distance

Mid-range Vision: computer, menus, price tags, Cooking, board games

- Prefer no mid-range glasses
- I wouldn't mind wearing mid-range glasses

Near Vision: reading books & newspapers, Doing detailed handiwork

- Prefer no near glasses
- I wouldn't mind wearing near glasses

2. Please check the single statement that best Describes you in terms of **night vision**:

- Night vision is extremely important to me And I require the best possible quality.
- I want to be able to drive comfortably at Night but I would tolerate some slight Imperfections.
- Night vision is not important to me.

3. If you had to wear glasses after surgery For only one activity, for which type of activity Would you be most willing to wear glasses?

- Distance Vision (driving, watching TV)
- Mid-range Vision (computer, dashboard)
- Near Vision (reading fine print)

4. If you could have good distance vision during the day without glasses and good near vision for reading without glasses, but the compromise was That you might see some halos or rings around lights at night, would that be ok?

Yes or No

5. If you could have good distance vision and Mid-range vision during the day and night without glasses, but the compromise was that you might need glasses for reading the finest print at near, would you like that option?

Yes or No

6. How many hours per day do you spend:

_____ on the computer?

_____ reading books, newspapers or small print?

_____ driving?

7. List your favorite hobbies or work activities:

8. Place an "X" on the scale to describe your Personality as best you can:

[-----]

Easygoing

Perfectionist

Signature: _____

Date: _____



Pre-Operative Questions for Cataract Surgery

Patient Name: _____

1. Yes or No Have you worn contact lenses within the past two weeks?

If Yes: Soft Contact Lens', please do not wear for 2 weeks prior to consult
Hard Contact Lens', please do not wear for 1 month prior to consult

2. Yes or No Have you ever had any eye surgery before? (LASIK, LASEK, PRK, RK, cornea, strabismus etc.)

3. If yes what type of eye surgery: _____

If the surgery was LASIK was it for nearsighted or farsighted: _____

4. Yes or No Have you ever used any of the following medicines (even once) -- circle medicine:
(usually for prostate or urinary problems)

Flomax or Tamsulosin

Uroxatral or Alfuzosin

Cardura or Doxazosin

Rapaflo or Silodosin

Minipress or Prazosin

Proscar or Finasteride

Hytrin or Terazosin

Avodart or Dutasteride

Saw Palmetto

Patient Signature

_____/_____/_____
Date