at UC Health Harmony Campus
2121 E. Harmony Rd., Suite 350A
Fort Collins, CO 80528
Ph # (970) 214-8175 / Fx # (970) 788-7376

NEW PATIENT REGISTRATION

Patient Name (First / Middle Initial / Last):

____

Patient Date of Birth (MM/DD/YY): ______________________________

Gender (circle one): Female Male Non-binary Prefer not to say

Preferred Phone Number: (______)________________________

Would you prefer (circle one or all): Calls Text Messages Emails

Preferred Email Address:

____

Mailing Address:

____

City: ____ **State:** _____________ **Zip Code:** ______________________

Parent / Guardian / Emergency Contact Information (Guardian required if Patient is under the age of 18)

Name (First / Last):

____

Preferred Phone Number (if different): (______)________________________

Preferred Email (if different): ____

Pediatrician / Primary Care Physician Name and Phone Number (if known):

____

How did you hear about us?

____

Children's Eye Care
OF NORTHERN COLORADO

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PEDIATRIC MEDICAL HISTORY FORM

Patient Name (First / Middle Initial / Last):

____

Patient Date of Birth (MM/DD/YY): _________________________

Gender Assigned at Birth (circle one): Female Male Prefer not to say

Date of Last Eye Exam (MM/DD/YY): _________________________

Current Gender Identity Female Male Non-binary

KNOWN ALLERGIES: Does the patient have allergies to any medication (circle one)? YES NO

If yes, please list ____

MEDICATIONS (please list all medications the patient is currently taking, including vitamins & supplements):

_________________________ _________________________ _________________________

_________________________ _________________________ _________________________

LIST ANY EYE MEDICATIONS:

____

____

LIST ANY EYE SURGERIES/LASERS (indicated which eye/year):

____

____

MEDICAL HISTORY (please check the box for any current or past treatment the patient has undergone):

☐	Asthma	☐	Developmental Delay	☐	Heart Murmur	☐	Arthritis
☐	Bronchopulmonary Dysplasia	☐	Attention Deficit Disorder	☐	Eczema	☐	Back/Neck Problems
☐	Diabetes	☐	Genetic Disorder	☐	Diarrhea	☐	Autoimmune Disease
☐	Prematurity	☐	Congenital Heart Defect	☐	Thyroid Problems	☐	Kidney/Urinary Problem
☐	Sleep Apnea	☐	High Blood Pressure	☐	Anemia	☐	Herpes
☐	ENT Problems	☐	Drug Exposure in utero	☐	Bleeding Disorders	☐	Skin Conditions
☐	Hearing Loss	☐	Torticollis (bent neck)	☐	Constipation	☐	Seasonal Allergies
☐	Sinus Problems	☐	Stroke	☐	GI Problems	☐	Anxiety/Depression
☐	Headaches	☐	Plagiocephaly (flat spot on head)	☐	GYN Problems	☐	Other Psych Disorder
☐	Seizures	☐	Tumor	☐	Prostate Problems	☐	Cancer ______________
☐	Other Illnesses/injuries:						

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SURGICAL HISTORY (please list all prior surgeries and the date [year]):

____

____

SOCIAL HISTORY (please circle all that apply):

Who does the patient live with? (ex: parent/s, family member, adoptive family, foster family) ______________

Does the patient have siblings? YES NO Number of Brothers ______ Number of Sisters _________

Does the patient attend school? YES NO If so, what grade? _______ Doing well? YES NO

Any recreational drug use? YES NO What type?______________

FAMLY HISTORY (please select any family conditions and list relationship to patient i.e. mother, father, etc):

☐	Glasses younger than age 6 _________________	☐	Glaucoma_________________________
☐	Diabetes ____________________________	☐	Genetic eye disease ____________________
☐	Cancer ____________________________	☐	Cataracts in childhood _____________________
☐	Heart Disease ___________________________	☐	Lazy Eye / Crossed Eye ______________________
☐	Retinal Detachment ________________________	☐	Other __________________________________

BIRTH HISTORY (please answer yes or no for each condition and use the space to the right to explain.)

	YES	NO	IF YES, PLEASE EXPLAIN
Problems with pregnancy			
Gestational Diabetes			
Born premature			
Born late			
Cesarean Section			
Baby required to stay in the hospital or NICU			
Intrauterine growth restriction or low birth weight			
High birth weight			
Jaundice			

EYE HISTORY: Has the patient ever been treated for:

☐	Cataracts	☐	Iritis/Uveitis
☐	Glaucoma	☐	Retinopathy of prematurity
☐	Amblyopia (lazy eye)	☐	Strabismus (crossed eye)
☐	Eye allergies	☐	Stye
☐	Eye injury ______________________________	☐	Other __________________________________

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IS THE PATIENT EXPERIENCING ANY OF THE FOLLOWING EYE SYMPTOMS? Circle one, if yes, please explain:

Does the patient wear glasses? YES NO ____

Does the patient wear contacts? YES NO ____

Does the patient have blurred vision? YES NO ____

Trouble with night vision/dim light? YES NO ____

Light sensitivity? YES NO ____

Dryness? YES NO ____

Tearing? YES NO ____

Itching/allergies? YES NO ____

Mucous discharge? YES NO ____

Redness? YES NO ____

Foreign body sensation? YES NO ____

Infection eye or lid? YES NO ____

Eye pain / soreness? YES NO ____

Double vision? YES NO ____

Loss of central or peripheral (side) vision? YES NO ____________________________________

Floaters/flashes of light? YES NO ____

Crossed eye? YES NO ____

Drooping eyelid? YES NO ____

IS THERE ANYTHING ELSE YOU WOULD LIKE US TO KNOW ABOUT THE PATIENT?

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FINANCIAL POLICY AND BILLING DISCLOSURE

Thank you so much for choosing Children's Eye Care of Northern Colorado – we are very excited to take care of you and your family. We ask that you please read this section carefully and if you have questions, please do not hesitate to ask us.

- On arrival, you may be asked to provide a current health insurance card. It is likely you will be asked to provide this information each time you visit us. We use this information to send billing information to your insurance provider either on our behalf or yours
- If you do not have insurance or would prefer not to bill your insurance, please let us know, and we will bill you directly. Payment is due at the time of service
- We ask that you provide complete insurance information to us so that we can file claims accurately. Any inaccurate or incomplete information may result in a claim being denied in which case you will be responsible for the entirety of the cost of service
- **Please check with your insurance provider prior to your visit if you have questions about your personal network status and any patient responsibility (co-insurance, deductible, non-covered charge and / or copay) that could be required. We will always collect co-pays and a refraction fee at the time of service**
- Unfortunately we do not participate in every insurance plan. We are "in-network" with most providers and are adding new providers regularly. If you have a question as to whether your insurance provider is "in-network" with us, please ask
- If we are "in-network" we will bill you for co-pays and a refraction fee at the time of service, and we will submit the covered charges to the insurance provider to reimburse us for the balance of service charges. Any allowed charges that are not reimbursed by the insurance company directly to us will be your responsibility. If your insurance company pays for the refraction we will refund you
- If we are "out-of-network" we will bill you for all service charges at the time of service and will submit our charges to your insurance provider on your behalf. Any reimbursements from your insurance provider will come directly to you
- **We do not currently participate in any vision plans**
- **Even if we are "in-network" with your insurance provider, your specific plan may not cover all of the allowed charges. Those charges will be billed directly to you. Please contact your insurance provider with questions regarding patient responsibilities**

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- Patient responsibility payments, other than those collected at the time of service (such as a co-payment) are due immediately upon billing
- Patient responsibility payments not made within 30 days of receipt of invoice will be subject to a $50.00 fee, and past 60 days will be subject to a $100.00 fee
- We require any unpaid balances to be paid before follow-up appointments can be made
- We understand that life happens and sometimes appointments need to be moved or canceled. We ask that any changes required are made as soon as possible. Unfortunately we cannot make changes or cancel within 24 hours of your scheduled appointment
- No shows (i.e. missing your appointment or failing to move / cancel your appointment at an appropriate time) will be charged a $50.00 fee
- We are happy to accept personal checks. We do charge $25.00 for returned checks (plus bank fees)
- In the event a procedure / surgery is required, you will not only receive bills from us but you will likely have bills from other parties (the surgical center, etc)
- You are ultimately responsible for keeping your account current with us. We will do our best to reach out to you when there are any issues with your account so you are not surprised
- As hard as we try not to, it is possible that we will overcharge some in-network patients at the time of service. If this happens we will reimburse you as soon as we discover you overpaid, hopefully within 30 days but certainly not more than 60 days (this will depend entirely on the time it takes for your insurance company to reimburse us, which sadly can be very unpredictable)
- We retain the right to attempt to collect unpaid balances (which hopefully won't happen!). If we are required to take legal action you understand that you are responsible for reasonable attorney fees and costs incurred to collect
- We are happy to provide you with a current rate card showing cost of individual services (listed as CPT codes) upon request

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BALANCE BILLING RIGHTS

Any service charges that are not covered by your insurance provider and / or co-pays / cost-sharing amounts / deductibles required by your health plan are your responsibility.

When we are out-of-network and we bill the difference between what your insurance provider decides is the eligible charge for a covered service and what we bill as the total charge, it is referred to as "balance" billing. Colorado and federal law protect against balance billing **ONLY** for emergency services or when an out-of-network provider provides a covered service at an in-work facility (which could be the case for surgeries provided through us). **IMPORTANTLY** this law does **NOT APPLY** to all health plans. For Colorado law, it only applies if you have a "CO-DOI" on your health insurance ID card. For federal law, it only applies if you receive insurance through your employer, the Health Insurance Marketplace or individual plans purchased directly through your insurer.

In such cases:

Emergency Services: If you receive covered emergency services, in most cases, the most you can be billed is your in-network cost sharing amounts. You cannot be balance-billed other amounts. This includes both the provider and the facility. We do not provide emergency services. If you believe you are experiencing an emergency please dial 911.

Non-Emergency Services: If we provide a service at an in-network facility (such as a surgical center), you have the right to request that in-network providers perform all covered charges, and if one is not available, the most you can be billed for covered services is your in-network cost-sharing amount (i.e. copayment, deductible, coinsurance, etc), and you cannot be balanced billed for additional charges.

Additional Protections:

- Your insurance carrier will pay out-of-network providers/facilities directly for covered services
- Your insurance carrier must count any amount you pay for emergency services toward your in-network deductible and out-of-pocket limit
- Your provider, facility, hospital, or agency must refund any overpayment within 60 days of being notified
- No one can ask you to give up these rights

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CONSENT

Any charges that are not paid for by insurance will be your responsibility. You have the right to request a "good faith estimate" of costs for your visit with us, which can be provided in writing within 3 business days of your request. We will attempt to help answer any questions that you have either in person, by phone or by email. **However, it is your responsibility to know your health care benefits and coverage limitations.**

Questions, concerns or complaints (hopefully not complaints) can be submitted to:

info@childrensnoco.com

Children's Eye Care of Northern Colorado, P.C.

Phone: (970) 214-8175, Fax: (970) 788-7376

An online complaint can also be made with the State of Colorado by visiting:

https://doi.colorado.gov/for-consumers/file-a-complaint or

https://www.colorado.gov/pacific/dora/DPO_File_Complaint

For more information about federal protections under the No Surprises Act, visit:

https://www.cms.gov/nosurprises

I have read and understand this Policy and Disclosure and accept responsibility for any payments that become due as outlined above. I agree to pay for all services rendered which are not paid for by my insurance and to notify this office should there be any change to my health insurance coverage.

____ _________________________

Patient or Person with Authority to Consent Date

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Children's Eye Care of Northern Colorado, P.C.

Notice of Privacy Practices for Protected Health Information (PHI)

THERE IS A LOT OF IMPORTANT INFORMATION HERE - PLEASE READ IT CAREFULLY. THIS NOTICE DESCRIBES HOW WE COLLECT AND USE INFORMATION ABOUT OUR PATIENTS AND HOW OUR PATIENTS CAN ACCESS THIS INFORMATION. IF YOU HAVE QUESTIONS ABOUT ANYTHING HERE PLEASE DON'T HESITATE TO ASK US.

Notice Effective Date: *October 1st, 2023*

Children's Eye Care of Northern Colorado, PC (Children's NoCo) is required by state and federal laws to maintain the privacy of your health information. Protected Health Information (PHI) is the critical information we collect and maintain in order to provide effective care to our patients. This information may include documentation of symptoms, exams, test results, diagnosis, treatment protocols and family history. Additionally patient information could include billing information for our patients and / or their families. Children's NoCo is allowed under HIPAA laws (the Health Insurance Portability and Accountability Act of 1996) to use and disclose your PHI without written authorization for purposes of treatment, payment and our general operations.

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Some examples of using PHI for treatment include:

1) Our physician or technician obtains and records treatment information about our patients and documents that information in our system
2) Our physician shares treatment information about our patients with their primary care provider or other specialists to obtain input
3) We may contact our patients or their parent / guardian by phone to discuss a medical condition and / or treatment or to remind them of upcoming appointments

An example of using PHI for payment / billing:

1) We may submit our patients' information to their health insurance company to obtain a reimbursement either on behalf of Children's NoCo or our patients themselves. Through this process we may be required to submit specific information about the treatment protocols for the patient or other patient specific information

An example of using PHI for our operations:

1) During the course of operating and improving Children's NoCo, we may use patient information for quality assessments, employee reviews, and / or student training. We may retain third parties to help us in this process, and our patient information could be disclosed to those parties as a result

PATIENTS RIGHTS

While Children's NoCo owns the patients records themselves, the patient owns the information within them. As a result, patients have the rights to:

1) Obtain a physical or digital copy of our current Notice of Privacy Practices at any time
2) Receive a notification if there is ever a breach of their information
3) Request a restriction on the use of their information. In many cases we will still be required to share some information required for effective care; however, we will always grant a request to refrain from sending patient information to a health insurance provider. Patients should understand this will require full out-of-pocket payment at the time of service
4) Request access to their maintained records in physical form. This request must be delivered in writing to our office, and the request may take up to 30 days to fulfill

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5) Appeal a denial of access to their PHI
6) Request that their maintained records be updated and / or amended to correct incomplete or incorrect information. This request must be delivered in writing to our office, and the request may take up to 30 days to fulfill. We may deny the request for various reasons including:
    a. The information was not created by us (unless the party that created the information is no longer available to make the change)
    b. Is not part of the information kept in our records
    c. Is not part of the information a patient would be allowed to access and inspect
    d. Is accurate or complete
7) Should a patient's request to update or amend their information be denied, Children's NoCo will notify the patient of the decision with our reasoning. The patient will then have the opportunity to submit a statement of disagreement in writing, which we will place in their record
8) Request alternative methods of communication for the patient's information (other than phone). All requests must be made in writing
9) Request information be released to other health care providers or other parties as they deem necessary. All requests must be made in writing
10) Opt-out of any communication from our practice that is not medically necessary
11) Obtain a list of instances where a patient's information was shared with outside parties as required by HIPAA
12) Revoke or change any prior authorizations to disclose information to third parties. Such revocations must be made in writing and delivered to the office

OUR COMMITMENTS

1) We will maintain the privacy of our patient's information as required by law
2) We will notify our patients following any breach of their information
3) We will provide our Notice of Privacy Practices and abide its terms
4) We will accommodate every patient request that we are reasonably able to
5) We will notify our patients if we cannot accommodate a request
6) We will not disclose patient information to their health insurance provided they provide written notification of the request (which we can provide) AND pay out of pocket at the time of service

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7) We reserve the right to change the terms of this Notice at any time. If we do make a change to the Notice, our patients will receive the most updated notice upon request

OTHER USES AND DISCLOSURES OF PATIENT PHI

We may use PHI in communication with members of the patient's family or guardians. We will of course use our best judgment in any communication with family or guardians (or any other party designated by the patient). If the patient objects to disclosure of their information to any family member or listed guardian, we will honor those wishes unless it becomes medically necessary to do so.

Unless a patient objects, we may use their information to notify a family member or guardian who is responsible for the patient's care of their location or general condition.

We may disclose patient information (in whole or in part) for medical research if an institutional review board has reviewed the research and established protocols privacy of patients PHI.

We may disclose patient information to assist in disaster relief efforts.

We may disclose to the FDA a patient's PHI relating to adverse events related to food, supplements, or products to enable product recalls, repairs or replacements.

If a patient is seeking compensation from Worker's Compensation, we may disclose their PHI to the extent necessary to comply with applicable Worker's Compensation laws.

We may disclose a patient's PHI to public health or legal authorities charged with preventing or controlling disease, injury, or disability; to report reactions to medications or problems with products; to notify people of recalls; or to notify a person who may have been exposed to a disease or who is at risk for contracting or spreading a disease or condition.

We may disclose patient PHI as required by law or to appropriate public authorities as allowed by law to report abuse or neglect.

In the event we are providing patient care at the request of a patient's employer, we may release patient information to the employer at their request to facilitate an evaluation of their workplace safety or to evaluate whether the patient has a workplace related injury. Any

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disclosure to a patient's employer will require a specific written release of the information by the patient.

We may disclose patient PHI to law enforcement officials in response to a court order / subpoena, warrant or similar judicial process. Additionally, we may disclose patient PHI to help locate a suspect, fugitive, material witness or missing person. We may disclose patient PHI if the patient was a victim of a crime, and we are unable to gather a written release from the patient directly. We may disclose patient PHI if there is criminal conduct on our premises or in limited emergencies where the disclosure is important in reporting a crime.

We may release patient PHI to appropriate health oversight agencies such as state and federal auditors.

We may disclose patient PHI in the course of any judicial or administrative proceeding as required by law, with a court order, or at the written consent of the patient.

For patients that are in the care of a facility, we may disclose patient PHI to the administrators of the facility necessary for the treatment of the patient or for the patient's safety.

We may release patient PHI to medical examiners, coroners, or funeral directors in the unfortunate situation where it may be necessary to determine identity or cause of death.

Other uses or disclosures of patient PHI than described in this document will not be made without patient authorization, unless otherwise required by law. Any disclosure of patient PHI to a third party for marketing purposes or that constitute a sale of patient information WILL require patient authorization. A patient or their parent or guardian may revoke any authorization at any time by submitting a written request to our office.

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To request information, exercise a right, or file a complaint, patients or their parents or guardians may contact us directly at (970) 214-8175, or in writing to us at:

Michael Mitchell
Children's Eye Care of Northern Colorado, P.C.
2121 E. Harmony Rd., Suite 350A
Fort Collins, CO 80528

Please note that all complaints, revocations, and requests for information must be submitted in writing to the address above. They may also file a complaint with the Secretary of Health and Human Services (HHS), Office for Civil Rights (OCR). The complaint must be filed in writing, either on paper or electronically, by mail, fax, or e-mail. The address for the Colorado regional office is: Office for Civil Rights, U.S. Department of Health and Human Services, 999 18th St., Suite 417, Denver, CO 80202; or call (800) 368-1019. More information regarding the steps to file a complaint can be found at: www.hhs.gov/ocr/privacy/hipaa/complaints.

WE CANNOT AND WILL NOT REQUIRE PATIENTS TO WAIVE THE RIGHT TO FILE A COMPLAINT WITH THE SECRETARY OF HHS AS A CONDITION OF RECEIVING TREATMENT.

WE CANNOT AND WILL NOT RETALIATE AGAINST PATIENTS FOR FILING A COMPLAINT WITH THE SECRETARY OF HHS.

Please affirm that you have read and understand the Notice of Privacy Practices:

I acknowledge that I have received and read the Notice of Privacy Practices from Children's Eye Care of Northern Colorado, P.C. and understand the content and terms.

___________________________________	___________________________________
Patient Name	Patient Signature
___________________________________	___________________________________
Guardian Name	Guardian Signature

Date: ______________________________