MONTGOMERY EYE CARE
EYE SURGERY CENTER OF COLORADO

Patient Information Sheet

Date: _____

Patient Name: _____ Gender: Male Female

Date of Birth: _____ Age: _____

Ethnicity: (circle one) Hispanic Non-Hispanic American Indian/Alaskan Native Asian

African American Caucasian Other

Address: _____City: _____ST:_____ZIP _____

Hm Phone#: _____ Alt Phone#: _____ Marital Status: _____

Alt Address: _____City: _____ST:_____ZIP _____

Primary Care Physician: _____ Referring Physician:_____

Emergency Contact

In Case of Emergency Please Call: _____

Hm Phone#: _____Alt Phone#:_____ Relationship: _____

MONTGOMERY EYE CARE

EYE SURGERY CENTER OF COLORADO

James Montgomery, M.D.

INSURANCE VERIFICATION & FINANCIAL POLICY

PATIENT NAME: _____

HEALTH INSURANCE COMPANY NAME: _____

Insured's Name:	Relation to Patient:
Group Number:	Insured's Policy ID Number:
Insured's Date of Birth:	Is There a Deductible? YES NO
	If Yes, how much?

DO YOU HAVE A SEPARATE *VISION* INSURANCE PLAN? YES NO
VISION INSURANCE COMPANY NAME:

SECONDARY INSURANCE	
Insured's Name:	
Group #	Relation to Patient:
Insured's Date of Birth:	Insured's Policy ID Number:

OUR FINANCIAL POLICY AND HOW IT WORKS FOR YOU
Whether you are self-pay or using your insurance, you are ultimately responsible for your bill.
Payment is due at the time of service. Please make necessary arrangements prior to your appointments.
We do not accept Medicaid as primary Insurance.
We do not bill Third Party Insurance

A refraction charge (to determine a glasses/contact lens prescription) of $35.00 may or may not be covered by insurance. You may be billed for this service if it is denied.

_____

Initial of Patient or Responsible Party

MONTGOMERY EYE CARE

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James Montgomery, M.D.

INSURANCE VERIFICATION & FINANCIAL POLICY

OUR RESPONSIBILITIES
We will bill your primary insurance. Your secondary insurance is a courtesy.
We will correct any errors we have made when there is a billing dispute.
We will provide guidance in getting your bills paid.

YOUR RESPONSIBILITIES
Please know and understand your insurance coverage. We are unable to verify the details of your insurance plan, i.e. deductibles, coinsurance, etc.
In most cases, we are given only 90 days to bill insurance so if accurate information is not given at the time of service; you will be responsible for payment.
Please pay your copayment at the time of your treatment.
Please read and keep your Explanation of Benefits statement from your insurance company.
Please follow up promptly with claims that are not paid by your insurance compay, or you will be billed directly for them.

CANCELLATION POLICIES:
Please make any cancellation with at least 12 hours notice or you may be billed for an office visit.
If your care or treatment requires surgery, and you cancel your surgery with less than 24 hours notice, you may be charged a late cancellation fee of $250. *This fee can later be applied to your procedure charges.

By signing below, you acknowledge that you have read, understood, and will agree to abide by our financial policy.

_____ _____

Patient Name PRINTED Date

_____ _____

Patient Signature/or person authorized to sign Date

MONTGOMERY EYE CARE, PC

Excellence in Eye Surgery and Advanced Diagnostics

Jim E. Montgomery MD Sieglinde Freed PhD

10465 Melody Drive Suite #111
Northglenn, CO 80234

Telephone: 303.252.9981
Fax: 303.252.7306

HIPAA PRIVACY NOTICE CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose Protected Health Information about you. The Notice contains a Patient 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.

You have the right to request that we restrict how Protected Health Information about you is used or disclosed for treatment, payment or healthcare 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 healthcare 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. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected Health Information may be disclosed or used for treatment, payment or healthcare operations.
- The Practice has a Notice of Privacy Practices and that that patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their information, but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time, and all future disclosures will then cease.
- The Practice my condition treatment upon the execution of this Consent.

_____ _____

Patient Name PRINTED Date

_____ _____

Patient Signature/or person authorized to sign Date

MONTGOMERY EYE CARE PC
10465 Melody Drive #111
Northglenn,CO 80234
Phone: 303-252-9981

Name:_____

Date:_____

DOB:_____

Circle "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	Yes	No	Hepatitis (Type__)	Yes	No
Arthritis	Yes	No	High Blood Pressure	Yes	No
Artificial Heart Valve	Yes	No	Kidney Disease	Yes	No
Artificial Joints	Yes	No	Lupus	Yes	No
Asthma	Yes	No	Migraine Headaches	Yes	No
Bleeding	Yes	No	Pacemaker	Yes	No
Blood Clots	Yes	No	Rheumatic Fever	Yes	No
Cancer	Yes	No	Shingles	Yes	No
Chemical Dependency	Yes	No	Skin Conditions	Yes	No
Diabetes	Yes	No	Sleep Apnea	Yes	No
Emphysema	Yes	No	Stroke	Yes	No
Epilepsy	Yes	No	Thyroid Conditions	Yes	No
Hay Fever	Yes	No	Tuberculosis	Yes	No
Heart Condition	Yes	No	EVER taken Flomax?	Yes	No

FAMILY HISTORY OF:

Yes	No	Cataracts
Yes	No	Diabetes
Yes	No	Glaucoma
Yes	No	Retinal Detachment
Yes	No	Macular Degeneration

# of children_____

Are you pregnant?_____

Alcohol use_____

Tobacco use_____

ALL SURGERIES AND DATES:

_____

_____

_____

_____

CURRENT MEDICATIONS:

Eye: _____

_____

Other Medications: _____

_____

DRUG ALLERGIES:

_____

_____

_____

_____

Primary Physician_____

Date of last visit_____

Pharmacy: _____

Eye Doctor_____

Date of last eye exam_____

Do you wear glasses? Yes No

When? (circle): All the time TV Occasionally Driving Reading

Do you wear contacts? Yes No

Type_____ Hrs/Day_____

Describe any problems you have with your contacts_____

Eye Health

Circle "Yes" or "No" if you are **PRESENTLY** experiencing any of the following:

Blurred Vision-Distance	Yes	No	Glaucoma	Yes	No
Blurred Vision-Near	Yes	No	Headaches	Yes	No
Burning Eyes	Yes	No	Itching Eyes	Yes	No
Cataracts	Yes	No	Light Sensitivity	Yes	No
Color Vision, Poor	Yes	No	Loss of Vision	Yes	No
Crossed Eyes	Yes	No	Migraine Headaches	Yes	No
Discharge from Eyes	Yes	No	Red Eyes	Yes	No
Dizzy Spells	Yes	No	Seeing Halos	Yes	No
Double Vision	Yes	No	Seeing Flashes	Yes	No
Dry Eyes	Yes	No	Temp Loss of Vision	Yes	No
Eye Infection	Yes	No	Vision Poor	Yes	No
Eye Injury	Yes	No	Watering Eyes	Yes	No
Floaters or Spots	Yes	No			