PATIENT REGISTRATION

McCRACKEN
EYE AND FACE INSTITUTE
11960 LIONESS WAY
SUITE 160
PARKER, CO 80134

Welcome to our office. We are committed to providing the best, most comprehensive care possible. We encourage you to ask questions. Please assist us by providing the following information. All information is confidential and is released only with your consent.

Patient Name	Today's Date	Date of Birth	Sex	Age
Parent if Patient is a Minor		Email Address		
Patient's Social Security Number				
Home Address	City	State	Zip Code	
Mailing Address if Different	City	State	Zip Code	
Primary Telephone Number		Secondary Telephone Number		
Occupation		Employer's Name		
Employer's Address	City	State	Zip Code	
Spouse Name		Employer		
Primary Physician's Name		Telephone Number		
Reason For Visit		Whom May We Thank for Referring You to Our Practice?		
FINANCIAL INFORMATION: PERSON RESPONSIBLE FOR FEES				
Name		Telephone Number		
Address	City	State	Zip Code	
Insurance Company		Claim Address		
Subscriber's Name		Subscriber's Date of Birth	Subscriber's SSN#	
Insurance ID Number				
Secondary Insurance		Claim Address		
Subscriber's Name		Subscriber's Date of Birth	Subscriber's SSN#	

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PATIENT HISTORY

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PAST SURGICAL PROCEDURES

Date	Type	Comments

MEDICATIONS

Name of Medication	Amount	Times Per Day

ALLERGIES

GENERAL MEDICAL HEALTH

PLEASE CHECK ANY SYMPTOMS THAT YOU ARE EXPERIENCING NOW OR HAVE EXPERIENCED IN THE PAST:

- ☐ Chest Pain
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Irregular Heartbeat
- ☐ Pacemaker
- ☐ Epilepsy or Seizures
- ☐ Fainting
- ☐ Fever or Chills
- ☐ Nausea, Vomiting, Diarrhea
- ☐ Unexpected Weight Loss or Gain
- ☐ Sinus Disorder
- ☐ Hyperlipidemia
- ☐ Bleeding or Scaring Tendency
- ☐ Blood Clots
- ☐ Blood Transfusion
- ☐ HIV
- ☐ Depression
- ☐ Diabetic
- ☐ Migraines
- ☐ History of Cancer
- ☐ Respiratory Issues
- ☐ Stomach Absorptive Disorder
- ☐ Ulcers
- ☐ Bladder Problems
- ☐ Pregnant
- ☐ Currently Breast Feeding
- ☐ Kidney Problems
- ☐ Anemia
- ☐ Joint Pain
- ☐ Artificial Joints
- ☐ Limited Motion in Joints
- ☐ Muscle Weakness
- ☐ Paralysis
- ☐ Stroke
- ☐ Hepatitis B
- ☐ Keloid Former
- ☐ Numbness or Tingling
- ☐ Headache
- ☐ Attention Deficit Disorder (ADD)
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Shortness of Breath
- ☐ Pulmonary Embolus
- ☐ Tuberculosis
- ☐ Wheezing
- ☐ Thyroid-Hypo
  - ☐ Double Vision
  - ☐ Decreased VIsion
  - ☐ Bulging of the Eyes
- ☐ Thyroid-Hyper
  - ☐ Double Vision
  - ☐ Decreased Vision
  - ☐ Bulging of the Eye

Other _____

FAMILY HISTORY

- ☐ Malignant Hyperthermia
- ☐ Abnormal Bleeding
- ☐ Abnormal Clotting
- ☐ Anesthesia Problems
- ☐ Thyroid Disorders
- ☐ Heart Disease
- ☐ Alcohol Usage
- ☐ Smoking

Signature of Patient, Parent, Guardian or Personal Representative — Date

Please Print Name of Patient, Parent Guardian or Personal Representative — Relationship to Patient

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The McCracken Eye & Face Institute, P.C. team is dedicated to ensuring that you experience the highest quality medical care available regardless of payment methods you elect. If you have medical insurance we do our best to help you receive the maximum allowable benefits under your insurance plan. In order to achieve this, we must obtain your assistance in understanding our financial policy.

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INSURANCE

Your insurance policy is a contract between you and the insurance company. The McCracken Eye & Face Institute, P.C.'s relationship is with you and not the insurance company. On the same note, we extend a courtesy to our patients and file your claims for you; however, all charges are your responsibility from the date services are provided. As with the case of all contracts, you, the insured, are expected to know your policy and its regulations as agreed upon by you and your insurance company at the time of enrollment. This will include referrals, second opinions or prior authorization. Our experienced staff will gladly assist you with obtaining any precertification or prior authorization as needed. However, in the event of failure to provide accurate and up-to-date insurance information resulting in a denial and non-payment for services rendered, payment will be the responsibility of the patient or the insured. Out of pocket expenses such as deductibles, coinsurance and/or co payments are your responsibility to be paid at the time of service as stated in your contract with the insurance company. In the event that your insurance company does not cover certain tests that our physicians would deem medically necessary in your care, you would be financially responsible for the cost of these tests.

For a current list of insurance companies that The McCracken Eye & Face Institute, P.C. participates with please ask the office staff.

SELF PAY

Payments for non-covered services are to be paid at the time of service unless prior arrangements have been made with our billing department. This would include elective surgical procedures, which most insurance companies exclude, as well as any other non-medical cosmetic procedure or product. The McCracken Eye & Face Institute, P.C. gladly accepts cash, checks, Visa and MasterCard. There is a $25.00 returned check service charge.

I have read and fully understand and acknowledge the financial policy of McCracken Eye & Face Institute, P.C. I acknowledge and agree to pay for any services and tests that are not covered by my insurance plan.

PATIENT'S SIGNATURE / GUARANTOR'S SIGNATURE _____ DATE _____

PATIENT'S SIGNATURE / GUARANTOR'S SIGNATURE _____ DATE _____

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CONSENT TO USE OR DISCLOSE MEDICAL INFORMATION

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I authorize McCracken Eye & Face Institute, PC to use and disclose the health and medical information of _____ for the purposes of Treatment, Payment and Health Care Operations.*
(Name of patient)

- **Treatment** (includes activities performed by a physician, nurse, office staff, and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care providers. This consent includes treatment provided by any physician who covers our practice by telephone as the on-call physician).

- **Payment** (includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, precertification and preauthorization).

- **Health Care Operations** (includes the necessary administrative and business functions of our office).

You may review McCracken Eye & Face Institute, PC's Notice of Privacy Practices' for additional information about the uses and disclosures of information described in this CONSENT prior to signing this CONSENT. Please verify that you have received a copy of our Notice by placing your initials here _____ .

Because we have reserved the right to change our privacy practices in accordance with the law, the terms contained in the Notice may change also. A summary of the Notice will be posted in the lobby of our office indicating the effective date of the Notice in the upper right hand corner. We will offer you a copy of the Notice on your first visit to us after the effective date of the then current Notice. We will also provide you with a copy of the Notice upon your request.

As more fully explained in the Notice, you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment, and health care operations purposes. ***We are not required to agree to your request.*** If we do agree, we are required to comply with your request unless the information is needed to provide you emergency treatment. Other physicians who provide call coverage for our office are required to use and disclose your protected health information consistent with the Notice.

I understand that I have the right to revoke this CONSENT provided that I do so in writing, except to the extent that McCracken Eye & Face Institute, PC has already used or disclosed the information in reliance on this CONSENT.

_____ _____ (or)

DATE PATIENT'S SIGNATURE

_____ _____

DATE SIGNATURE OF PERSON AUTHORIZED BY LAW

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EMERGENCY AND CONFIDENTIAL PATIENT CONTACT PERSON:

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• *This is the only person to whom information will be released other than you, the patient.*

Name _____ Relationship _____

Address _____

Telephone _____ Date of Birth _____

Welcome to our practice. We are pleased to participate in your health care, and it is our primary concern to provide you with the best possible care for your eyes. The following is information concerning our financial policy. We will be happy to answer any of your questions professionally and confidentially.

We will bill your primary and secondary insurance for you as a courtesy. Please read the following authorization for insurance billing.

Release of Information/Financial Guarantee:

I give my permission to McCracken Eye & Face Institute, PC to bill my insurance company whether the benefits are to come to me or to McCracken Eye & Face Institute, PC. It is my understanding that I am eligible for medical benefits through my insurance. However, in the event that my insurance company categorizes services rendered to me as 'non-covered" or not medically necessary', I agree to pay in full for all such charges. I fully understand that it is my responsibility to advise the Office Manager if my insurance requires pre-admission review, pre-admission authorization, or a second opinion, or if it contains any special provisions (to include exclusionary rider) which must be satisfied before payment by the insurance company can be made. If I fail to advise the Office Manager of such policy requirements and to comply in good faith, I agree to pay in full for all such charges.

If I am a member of a managed care plan, I understand that it is my responsibility to make sure the correct referral is in place from my Primary Care Doctor. (Co-pays will be made at the time of service.) I understand I will be financially responsible for any and all charges at the time of service should a referral not be supplied by my Primary Care Doctor. For individuals with private insurance, the signature below authorizes direct assignment of benefits to the doctor.

_____ _____

PATIENT'S SIGNATURE / GUARDIAN SIGNATURE DATE

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