

<b>LEGAL FIRST:</b>	<b>MI:</b>	<b>LAST:</b>	<b>PREFERRED:</b>
<hr/>			
<b>MAILING ADDRESS:</b>	<b>CITY:</b>	<b>ST:</b>	<b>ZIP:</b>
<hr/>			
<b>DATE OF BIRTH:</b> / /	<b>LAST 4 OF SSN:</b>	<b>SEX: M / F</b>	<b>DRIVER'S LICENSE # &amp; STATE:</b>
<i>If you have given us your DL, you may skip this section.</i>			
<b>PRIMARY LANGUAGE:</b>	<b>RACE:</b>	<b>ETHNICITY: HISPANIC / NOT HISPANIC</b>	
<i>As a medical provider, we are obligated to ask the above; you are not required to answer.</i>			
<input type="checkbox"/> <b>HOME PHONE:</b>	<input type="checkbox"/> <b>CELL:</b>	<b>NAME OF SPOUSE:</b>	
<i>Check the box to indicate your preferred phone number.</i>			
<b>EMAIL:</b>	<b>PRIMARY CARE PHYSICIAN:</b>		
<hr/>			

### **REQUIRED FOR MINORS (17 & Under) – PARENT/LEGAL GUARDIAN INFO**

<b>LEGAL NAME:</b>	<b>MAILING ADDRESS:</b>
<i>Of Parent/Legal Guardian</i>	<i>If different than above</i>
<b>DATE OF BIRTH:</b> / /	<b>LAST 4 OF SSN:</b> <b>DRIVER'S LICENSE # &amp; STATE:</b>
<i>Of Parent/Legal Guardian</i>	
<b>RELATIONSHIP TO MINOR:</b>	<b>PHONE NUMBER:</b>
<hr/>	

### **INSURANCE INFORMATION** *If you have given your cards to our technicians, you may skip this section.*

<b>PRIMARY MEDICAL:</b>	<b>SECONDARY MEDICAL:</b>
<i>Please list only the name of the insurance provider.</i>	
<b>Do you have an additional or embedded vision benefit? YES / NO</b>	<b>VISION BENEFIT:</b>
<i>Please list only the name of the benefit provider.</i>	

### **DISCLOSURES** *Physicians and parents of minor children do not need to be listed.*

In addition to myself, I **authorize** the disclosure of any or all my patient record to the following people:

<b>LEGAL NAME:</b>	<b>RELATIONSHIP:</b>
<hr/>	<hr/>
<b>LEGAL NAME:</b>	<b>RELATIONSHIP:</b>
<hr/>	<hr/>

**NOTE:** If the parent of a minor is no longer permitted to access the records of the patient, legal documentation must be provided before access can legally be denied.

### **INITIAL & ACKNOWLEDGE** *Initial next to each of the following statements and sign below.*

- I acknowledge that insurance is a contract between me and my insurance company. It is my responsibility to know my policy and benefits. Collegiate Peaks Eyecare will make every attempt to determine coverage and file claims accurately. However, in the event of disputes regarding coverage, deductibles, copays, etc., it must be handled between me and my insurance provider.
- I acknowledge that I have had the opportunity to review a copy of the Notice of Privacy Practices of Collegiate Peaks Eyecare.
- I certify that the information provided here is accurate to the best of my ability. I authorize the release of any medical or other information necessary to process claims. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment of my medical benefits to the physician or supplier filing the claim. I understand that I am personally responsible for any charges incurred at Collegiate Peaks Eyecare including but not limited to my copays and deductibles.
- I understand that Collegiate Peaks Eyecare may be out-of-network for my selected insurance or benefit provider. If my insurance is out-of-network, I acknowledge that I have been made aware and that I would like to continue with my appointment and services understanding that I am responsible for all charges. I understand that I may ask additional questions and have had the opportunity to review the surprise/balance billing disclosure form.

By **initialing above** and **signing below**, I consent to and acknowledge my cooperation with the above statements.

<b>SIGNATURE:</b>	<b>DATE:</b>
<hr/>	<hr/>
<i>Patient or Parent/Legal Guardian</i>	

We understand that everyone hates paperwork; *we do too*. We ask these questions so that we can assess the health of your eyes and visual system to the best of our ability. We do much more than have you look at letters on the wall, and many seemingly unrelated health conditions can have a big impact on your vision. We want you to see the best that you can now and into the future.

Thank you for taking the time to participate in these questions; simply answer to the best of your knowledge.

LEGAL NAME: \_\_\_\_\_ DOB: / / \_\_\_\_\_ DATE: \_\_\_\_\_

REASON FOR TODAY'S VISIT: \_\_\_\_\_ DATE OF LAST EYE EXAM: \_\_\_\_\_

CURRENT MEDICATIONS: \_\_\_\_\_

*If you brought your list today, we are happy to copy it. Please also include any OTC medications or eye drops.*

ARE YOU ALLERGIC TO ANY MEDICATIONS?  YES  NO IF YES, PLEASE LIST THEM: \_\_\_\_\_

DO YOU HAVE A LATEX SENSITIVITY?  YES  NO OTHER ALLERGIES: \_\_\_\_\_

### PRESCRIPTION EYEWEAR HISTORY

DO YOU CURRENTLY WEAR GLASSES?  YES  NO IF YES, DO YOU WEAR THEM:  PART-TIME  FULL-TIME  
 I TYPICALLY USE MY GLASSES FOR:  WORK  DRIVING  READING  SAFETY  HOBBIES  
 OCCUPATION: \_\_\_\_\_ HOBBIES: \_\_\_\_\_

DO YOU WEAR SUNGLASSES?  YES  NO IF YES, DO YOU WEAR PRESCRIPTION SUNGLASSES?  YES  NO  
 DO YOU CURRENTLY WEAR CONTACTS?  YES  NO IF NO, ARE YOU INTERESTED IN TRYING CONTACTS?  YES  NO  
 IF YES, WHAT BRAND DO YOU WEAR? \_\_\_\_\_ HOW OFTEN:  PART-TIME  FULL-TIME

### SURGICAL HISTORY

#### OCULAR (EYE) SURGERIES

PROCEDURE:	YEAR:	EYE:	SURGEON:

#### NON-OCULAR SURGERIES

PROCEDURE:	YEAR:	SURGEON:

### SOCIAL HISTORY

ALCOHOL USE:  NONE  SOCIAL ONLY  1-2 DRINKS DAILY  3+ DRINKS DAILY  ALCOHOL DEPENDENCE  
 TOBACCO USE:  NEVER  FORMER  LIGHT  AVERAGE  HEAVY  
 OTHER SUBSTANCE USE:  NO  YES IF YES, TYPE & FREQUENCY: \_\_\_\_\_

PLEASE CONTINUE TO THE BACKSIDE OF THIS FORM

**PERSONAL MEDICAL HISTORY** *If you have every been diagnosed with the following, please check all that apply.*

CARDIOVASCULAR		INTEGUMENTARY		MUSCULOSKELETAL	
<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Rosacea / Eczema	<input type="checkbox"/>	Arthritis (Osteo)
<input type="checkbox"/>	Stroke / TIA	<input type="checkbox"/>	Dry Mouth / Swallowing Problems	<input type="checkbox"/>	Gout
<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	Psoriasis	<input type="checkbox"/>	Osteoporosis
<input type="checkbox"/>	Vascular Disease	<input type="checkbox"/>	Herpes Zoster (Shingles)	NEUROLOGICAL	
<input type="checkbox"/>	Other	HEAD/ENT/DENTAL		<input type="checkbox"/>	Bell's Palsy
<input type="checkbox"/>		<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	Brain Tumor
ENDOCRINE		<input type="checkbox"/>	Sinusitis	<input type="checkbox"/>	Multiple Sclerosis
<input type="checkbox"/>	Diabetes Type 1	<input type="checkbox"/>	Dry Mouth	<input type="checkbox"/>	Parkinson's Disease
<input type="checkbox"/>	Diabetes Type 2	<input type="checkbox"/>	Laryngitis	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	Hormonal Dysfunction	<input type="checkbox"/>		<input type="checkbox"/>	Migraines
<input type="checkbox"/>	Thyroid Disorder (High or Low)	HEMATOLOGIC/LYMPHATIC		PSYCHIATRIC	
GASTROINTESTINAL		<input type="checkbox"/>	Bleeding Abnormalities	<input type="checkbox"/>	Alzheimer's
<input type="checkbox"/>	Crohn's	<input type="checkbox"/>	Leukemia / Lymphoma	<input type="checkbox"/>	Anxiety
<input type="checkbox"/>	Colitis	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	Bi-Polar Disorder
<input type="checkbox"/>	Ulcer / Acid Reflux	<input type="checkbox"/>	Temporal Arthritis	<input type="checkbox"/>	Depression
<input type="checkbox"/>	Inflammatory Bowel Disease	<input type="checkbox"/>	Cancer:	<input type="checkbox"/>	Learning Disability
<input type="checkbox"/>	Celiac Disease	<input type="checkbox"/>		<input type="checkbox"/>	Schizophrenia
GENITOURINARY		IMMUNOLOGIC/ALLERGY		<input type="checkbox"/>	
<input type="checkbox"/>	Prostate / BPH	<input type="checkbox"/>	Autoimmune Disorders	RESPIRATORY	
<input type="checkbox"/>	Renal Disease (Kidney)	<input type="checkbox"/>	HIV / AIDS	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	Sexually Transmitted Disease	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	COPD
<input type="checkbox"/>	Syphilis	<input type="checkbox"/>	Sarcoidosis	<input type="checkbox"/>	Emphysema
<input type="checkbox"/>		<input type="checkbox"/>	Sjogren's Syndrome	<input type="checkbox"/>	Lung Cancer
CURRENTLY PREGNANT or NURSING		<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	Sleep Apnea
<input type="checkbox"/> Pregnant <input type="checkbox"/> Nursing		<input type="checkbox"/>		<input type="checkbox"/>	

**CURRENT EYE SYMPTOMS** *If you are experiencing the following, please check all that apply.*

<input type="checkbox"/>	Dry Eye	<input type="checkbox"/>	Eyestrain	<input type="checkbox"/>	Cataracts
<input type="checkbox"/>	Eye Infection or Inflammation	<input type="checkbox"/>	Eye Pain	<input type="checkbox"/>	Glaucoma
<input type="checkbox"/>	Floaters / Flashes of Light	<input type="checkbox"/>	Severe Sensitivity to Lights	<input type="checkbox"/>	Retinal Detachment
<input type="checkbox"/>	Iritis or Uveitis	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	Macular Degeneration
<input type="checkbox"/>	Retina Defect or Degeneration	<input type="checkbox"/>	Amblyopia/Lazy Eye	<input type="checkbox"/>	Sandy/Gritty Feeling
<input type="checkbox"/>	Redness	<input type="checkbox"/>	Poor Night Vision	<input type="checkbox"/>	Distorted Vision/Halos
<input type="checkbox"/>	Burning	<input type="checkbox"/>	Bothersome Night Glare	<input type="checkbox"/>	Loss of Side Vision
<input type="checkbox"/>	Itching	<input type="checkbox"/>	Double Vision	<input type="checkbox"/>	Fluctuating Vision
<input type="checkbox"/>	Excess Tearing/Watering	<input type="checkbox"/>	Total Loss of Vision	<input type="checkbox"/>	Foreign Body Sensation
<input type="checkbox"/>	Discharge	<input type="checkbox"/>	Tired Eyes	<input type="checkbox"/>	Other

**IMMEDIATE FAMILY HISTORY** *Please check all that apply, including only Parents, Siblings, and Children.*

Relationship to Patient		Relationship to Patient	
<input type="checkbox"/>	Amblyopia/Lazy Eye	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	Blindness	<input type="checkbox"/>	Diabetes Type 1 or 2
<input type="checkbox"/>	Cataracts	<input type="checkbox"/>	Heart Disease
<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	Retinal Detachment	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	Macular Degeneration	<input type="checkbox"/>	Thyroid Disease (H/L)

DR. MATTHEW L. SCOTT, O.D.

**cpeakseye.com**

PHONE: 719-581-4060

FAX: 719-631-2577

**ADVANCED BENEFICIARY NOTICE  
OF POSSIBLE COORDINATION OF BENEFITS AND/OR  
POTENTIALLY NON-COVERED SERVICES**

**INSURANCE DOES NOT GUARANTEE COVERAGE**

I understand that despite having insurance, some services may not be covered by my individual plan, including but not limited to contact lens and refraction services, and regardless of coverage that deductibles, copays, and denials may apply for which I am responsible.

**MY EXAM MAY INCLUDE BOTH MEDICAL AND ROUTINE COMPONENTS**

I understand that I may be seen by Collegiate Peaks Eyecare for routine or medical eye appointments and that the two may not be mutually exclusive. I acknowledge that Collegiate Peaks Eyecare can bill medical eye care and when appropriate, based on the guidance of my vision plan, may bill my medical insurance first and coordinate my benefits between medical and vision.

**DR. SCOTT WILL DETERMINE MY DIAGNOSIS AND TREATMENT PLAN WHICH MAY AFFECT MY BILLING**

I understand that regardless of my appointment type, Dr. Scott will determine my diagnosis and treatment plan based on the evidence presented during my exam which may require additional testing and billing through my medical insurance prior to my vision benefit.

**MY INSURANCE MAY SEND ME AN E.O.B.**

I understand that my insurance may send me an Estimation of Benefits (E.O.B.) explaining to me that they were billed for certain services I received at Collegiate Peaks Eyecare. I understand that this is **not** a bill from Collegiate Peaks Eyecare, **nor** is this an indication of money due to me by Collegiate Peaks Eyecare.

**IN GENERAL, VISION PLANS DO NOT COVER MEDICAL SERVICES**

I understand that while I may have a vision benefit, it may not cover medical services and that such services may require billing through my medical insurance.

SERVICES BEYOND ROUTINE / POTENTIALLY NON-COVERED

Refraction	\$35.00	OCT Imaging	\$65.00
CL Fit & Train	\$75.00	24-2 Threshold	\$85.00
CL Services 1	\$25.00	Fundus Photography	\$85.00
CL Services 2	\$35.00	Scleral/Specialty Lens Fitting	\$150.00
CL Services 3	\$50.00	Foreign Body Removal	\$95.00

**SELECT ONE OF THE FOLLOWING OPTIONS:**

**OPTION 1:** I understand and acknowledge the above statements and **choose to proceed** with my appointment understanding that my insurance or vision benefit may be billed accordingly.

**OPTION 2:** I understand and acknowledge the above statements and choose to proceed with my appointment; **HOWEVER, I waive my right to use insurance** and instead elect to be billed in full as a cash pay patient and that I am responsible for payment. Per HIPAA, I understand that if I pay cash for any services or materials then my insurance company cannot be billed, and I have no appeal rights.

**OPTION 3:** I understand the above statements and do **NOT** want to proceed with any potentially non-covered services.

By signing below, I consent to and acknowledge my cooperation with the above selected option.

PRINTED LEGAL NAME: \_\_\_\_\_ DOB:     /     /

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

*Patient or Parent/Legal Guardian*

**NOTICE OF PRIVACY PRACTICES**

Privacy Officer – Matthew L. Scott, O.D.

Effective Date – October 23, 2017

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

We care about our patients' privacy and strive to protect the confidentiality of your medical information at this practice. Federal legislation requires that we issue this official notice of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that protected health information. This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this Notice, please contact the Privacy Officer at this practice.

**Who Will Follow This Notice?**

Any health care professional authorized to enter information into your medical record, all employees, staff and other personnel at this practice who may need access to your information must abide by this Notice. All subsidiaries, business associates (e.g. a billing service), sites and locations of this practice may share medical information with each other for treatment, payment purposes or health care operations described in this Notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be shared.

**How We May Use and Disclose Medical Information About You:**

The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category of uses or disclosures. Not every possible use or disclosure in a category is listed.

**For Treatment:** We may use and disclose medical information about you to provide you with medical treatment or services. Example: In treating you for a specific condition, we may need to know if you have allergies that could influence which medications we prescribe for the treatment process.

**For Payment:** We may use and disclose medical information about you so that the treatment and services you receive from us may be billed and payment may be collected from you, an insurance company or a third party. Example: We may need to send your protected health information, such as your name, address, office visit date, and codes identifying your diagnosis and treatment to your insurance company for payment.

**For Health Care Operations:** We may use and disclose medical information about you for health care operations to assure that you receive quality care. Example: We may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

**Persons Involved in Your Care:** We may disclose medical information about you to a relative, close friend or any other person you identify if that person is involved in your care and the information is relevant to your care. Example: if the patient is a minor, we may disclose medical information about the minor to a parent, guardian or other person responsible for the minor except in limited circumstances.

**Required by Law:** We will use and disclose medical information about you whenever we are required by law to do so. There are many state and federal laws that require us to use and disclose medical information. Example: state law requires us to report gunshot wounds and other injuries to the police and to report known or suspected child abuse or neglect to the Department of Social Services. We will comply with those state laws and with all other applicable laws.

**National Priority Uses and Disclosures Made Without Your Consent or Authorization**

When permitted by law, we may use or disclose medical information about you without your permission for activities that are recognized as "national priorities." The government has determined that under certain circumstances, it is so important to disclose medical information that it is acceptable to disclose medical information without the individual's permission. Some examples include:

- Law enforcement or correctional institution, such as required during an investigation by a correctional institution of an inmate;
- Threat to health or safety, such as to avert or lessen a serious threat;
- Workers' compensation or similar programs, such as for the processing of claims;
- Abuse, neglect or domestic violence, such as if you are an adult and we reasonably believe you may be a victim of abuse;
- Health oversight activities, such as to a government agency to investigate possible insurance fraud;
- Court or legal proceedings, such as if a judge orders us to do so;
- Research organizations, such as if the organization has satisfied certain conditions about protecting the privacy of medical information;
- Coroner or medical examiner for identification of a body;
- Public health activities, such as required by the US Food and Drug Administration (FDA); and
- Certain government functions, such as using or disclosing for government functions like Military and veterans' activities and national security and intelligence activities.

**Uses and Disclosures of Protected Health Information Requiring Your Written Authorization**

The following uses and disclosures of medical information about you will only be made with your authorization (signed permission) from you or your personal representative:

- Uses and disclosures for marketing purposes.
- Uses and disclosures that constitute the sales of medical information about you.
- Most uses and disclosures of psychotherapy notes, if we maintain psychotherapy notes.
- Any other uses and disclosures not described in this Notice.

You have several rights with respect to medical information about you. This section of the Notice will briefly mention each of these rights. If you would like to know more about your rights, please contact our Privacy Officer.

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you give us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will thereafter no longer use or disclose medical information about you for the reason covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care we have provided you.

**Your Individual Rights Regarding Your Medical Information Complaints:** If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at this practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against for filing a complaint. To file a written complaint with us, you may bring your complaint directly to our Privacy Officer, or you may mail it to the following address: Collegiate Peaks Eyecare, PO Box 3179, Buena Vista, CO 81211. To file a written complaint with the federal government, please use the following contact information: Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201 OR Toll-Free Phone: 1-877-696-6775 OR <https://www.hhs.gov/hipaa/filing-a-complaint/index.html> OR Email: [OCRComplaint@hhs.gov](mailto:OCRComplaint@hhs.gov).

**Right to Request Restrictions on Uses and Disclosures:** You have the right to request that we limit the use and disclosure of medical information about you for treatment, payment and healthcare operations. Under federal law, we must agree to your request and comply with your requested restriction(s) if: 1. Except as otherwise required by law, the disclosure is to a health plan for purpose of carrying out payment of healthcare operation (and is not for purposes of carrying out treatment); and, 2. The medical information pertains solely to a healthcare item or service for which the healthcare provided involved has been paid out-of-pocket in full. Once we agree to your request, we must follow your restrictions (except if the information is necessary for emergency treatment). You may cancel the restrictions at any time. In addition, we may cancel a restriction at any time as long as we notify you of the cancellation and continue to apply the restriction to information collected before the cancellation. You also have the right to request that we restrict disclosures of your medical information and healthcare treatment(s) to a health plan (health insurer) or other party, when that information relates solely to a healthcare item or service for which you, or another person on your behalf (other than a health plan), has paid us for in full. Once you have requested such restriction(s), and your payment in full has been received, we must follow your restrictions(s).

**Right to Request Confidential Communications:** You have the right to request how we should send communications to you about medical matters, and where you would like those communications sent. To request confidential communications, you must make your request to the Privacy Officer at this practice. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. We reserve the right to deny a request if it imposes an unreasonable burden on the practice.

**Right to Inspect and Copy:** You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually this includes medical and billing records but does not include psychotherapy notes, information compiled for use in a civil, criminal, or administrative action or proceeding, and protected health information to which access is prohibited by law. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer at this practice. If you request a copy of the information, we reserve the right to charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by this practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

**Right to Amend:** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at this practice. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if the information was not created by us, is not part of the medical information kept at this practice, is not part of the information which you would be permitted to inspect and copy, or which we deem to be accurate and complete. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Statements of disagreement and any corresponding rebuttals will be kept on file and sent out with any future authorized requests for information pertaining to the appropriate portion of your record.

**Right to an Accounting of Disclosures We Have Made:** You have the right to receive an accounting (which means a detailed listing) of disclosures that we have made for the previous six (6) years. If you would like to receive an accounting, you may send us a letter requesting an accounting, fill out an Accounting Request Form, or contact our Privacy Officer. Accounting Request Forms are available from our Privacy Center. The accounting will not include several types of disclosures, including disclosures for treatment, payment or healthcare operations. If we maintain your medical records in an Electronic Health Record (EHR) system, you may request inclusion of disclosures for treatment, payment or healthcare operations. The accounting will also not include disclosures made prior to April 14, 2003. If you request an accounting more than once every twelve (12) months, we may charge you a fee to cover the costs of preparing the accounting.

**Right to Request an Alternative Method of Contact:** You have the right to request to be contacted at a different location or by a different method. For example, you may prefer to have all written information mailed to your work address rather than to your home address. We will agree to any reasonable request for alternative methods of contact. If you would like to request an alternative method of contact, you must provide us with a request in writing. You may write us a letter or fill out an Alternative Contact Request Form. Alternative Contact Request Forms are available from our Privacy Officer.

**Right to Notification if a Breach of Your Medical Information Occurs:** You also have the right to be notified in the event of a breach of medical information about you. If a breach of your medical information occurs, and if that information is unsecured (not encrypted), we will notify you promptly with the following information: 1. A brief description of what happened; 2. A description of the health information that was involved; 3. Recommended steps you can take to protect yourself from harm; 4. What steps we are taking in response to the breach; and, 5. Contact procedures so you can obtain further information.

**Right to Opt-Out of Fundraising Communications:** If we conduct fundraising and we use communications like the U.S. Postal Service or electronic email for fundraising, you have the right to opt-out of receiving such communications from us. Please contact our Privacy Officer to opt-out of fundraising communications if you chose to do so.

**Right to a Paper Copy of This Notice:** You have the right to a paper copy of this Notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy. To obtain a paper copy of the current Notice, please request one in writing from the Privacy Officer at this practice.

**Changes to This Notice:** We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice, with the effective date in the upper right corner of the first page.

**COLORADO**Department of  
Regulatory Agencies

Division of Professions and Occupations

## SURPRISE/BALANCE BILLING DISCLOSURE FORM

### SURPRISE BILLING – KNOW YOUR RIGHTS

Beginning January 1, 2020, Colorado state law now protects those with insurance cards containing CO-DOI from surprise billing, also known as balance billing, if they have received emergency services in a designated emergency room. These protections apply only when:

- You receive otherwise covered emergency services, other than ambulance services, from an out-of-network provider in Colorado, and/or
- You unintentionally receive covered services from an out-of-network provider at an in-network facility in Colorado
- You possess insurance valid in the state of Colorado and your insurance card contains CO-DOI

### IS COLLEGIATE PEAKS EYECARE CONSIDERED AN EMERGENCY FACILITY?

As a medical provider, Dr. Scott may treat patients with urgent eye-related concerns or injuries and patients may be referred to our office by an emergency facility. However, **Collegiate Peaks Eyecare is not an emergency facility.**

### DOES THIS APPLY TO ALL INSURANCE POLICIES?

No, this law does not apply to all Colorado health plans. It only applies if you have a CO-DOI listed on your health insurance ID card.

### WHAT IS SURPRISE/BALANCE BILLING, AND WHEN DOES IT HAPPEN?

If you are seen by a health care provider or use services in an emergency facility that is not in your health insurance plan's provider network, sometimes referred to as "out-of-network," you may receive a bill for additional costs associated with that care. Out-of-network health care providers often bill you for the difference between what your insurer decides is the eligible charge and what the out-of-network provider bills as the total charge. This is called surprise or balance billing.

### WHEN CAN I BE BALANCE-BILLED?

You can be balance-billed when you have received services at an out-of-network facility or with an out-of-network provider other than an emergency room. Collegiate Peaks Eyecare generally handles out-of-network services as cash pay and will provide you with out-of-network reimbursement paperwork if available. Please note that, if available, it is your responsibility to understand your out-of-network reimbursement benefits. Additionally, if you receive services from an out-of-network provider, facility or agency, you may still be balance-billed, or you may be responsible for the entire bill. If you intentionally receive nonemergency services from an out-of-network provider or facility, you may also be balance-billed.

### WHEN CAN'T I BE BALANCE-BILLED?

If you are receiving emergency services, the most you can be billed for is your plan's in-network cost-sharing amounts, which are copayments, deductibles, and/or coinsurance. You cannot be balance-billed for any other amount. This includes both the emergency facility where you receive emergency services and any providers that see you for emergency care. The health care provider must tell you if you are at an out-of-network location or at an in-network location that is using out-of-network providers. They must also tell you what types of services that you will be using may be provided by any out-of-network provider.

### WHAT ARE MY RIGHTS?

You have the right to request that in-network providers perform all covered medical services. However, you may have to receive medical services from an out-of-network provider at an emergency facility if an in-network provider is not available. In this case, the most you can be billed for covered emergency services is your in-network cost-sharing amount, which are copayments, deductibles, and/or coinsurance. These emergency providers cannot balance bill you for additional costs. Additional protections include:

- Your insurer will pay out-of-network providers and facilities directly.
- Your insurer must count any amount you pay for emergency services or certain out-of-network services (described above) toward your in-network deductible and out-of-pocket limit.
- Your provider, facility, hospital, or agency must refund any amount you overpay within sixty days of being notified.
- No one, including a provider, hospital, or insurer can ask you to limit or give up these rights.
- If you want to file a complaint against your health care provider, you can submit an online complaint by visiting this website: [https://www.colorado.gov/pacific/dora/DPO\\_File\\_Complaint](https://www.colorado.gov/pacific/dora/DPO_File_Complaint).

If you think you have received a bill for amounts other than your copayments, deductible, and/or coinsurance, please contact the billing department, or the Colorado Division of Insurance at 303-894-7490 or 1-800-930-3745. Please contact your health insurance plan at the number on your health insurance ID card or the Colorado Division of Insurance with questions.



## INSTRUCTIONS FOR ACCESS TO REVOLUTIONPHR

### YOUR PERSONAL CONFIDENTIAL PATIENT PORTAL

#### OVERVIEW

Collegiate Peaks Eyecare is pleased to offer you convenient, secure access to information from your eye care record through an online portal called RevolutionPHR. The acronym PHR stands for “**P**ersonal **H**ealth **R**ecord.” This represents an online location where you, and only you, can view important information about your relationship with us such as your prescriptions, invoices and exam records. We genuinely hope that you find value in having access to this information in a timely and secure environment.

RevolutionPHR utilizes the highest standards of online security while allowing you to view portions of your eye care record through any standard Internet browser on a PC, Mac or tablet. We encourage you to use the login information created specifically for you to review the many features available. You can decide if access to RevolutionPHR is right for you, and participation is completely optional. We have no record of what you do or do not access, and we allow you to use this online portal at your discretion.

#### WHAT INFORMATION CAN I ACCESS?

Through the secure online RevolutionPHR patient portal, you will have the option to schedule an appointment, access your exam records, print current prescriptions or previous receipts, review your orders, and more.

#### STEPS TO ACCESS REVOLUTIONPHR

1. **ACCESS THE INTERNET** – Using your preferred internet browser on any PC, Mac, or tablet, access the internet to enter the following domain information.
2. **GO TO REVOLUTIONPHR.COM** – In the internet address bar (often called the Toolbar), type this address: <https://www.revolutionphr.com>. This link is also available on our website at [cpeakseye.com](http://cpeakseye.com).
3. **INSERT YOUR UNIQUE USERNAME** – If you provided us with an email address at the time of your visit, your username will likely be the email address you provided. If this username does not work, contact us to receive your unique username.
4. **CLICK FORGOT PASSWORD** – In order to create your own unique and secure password, you will need to click “Forgot Password” to reset the password to one of your choosing. After you click, it will send you an email. Follow the instructions in the email and on the screen to reset the password. If you do not receive an email within 24 hours, contact our office. Depending on your privacy settings it is possible that your email server directed the email into your Spam or Junk folders.

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