Geeta Lalwani, M.D.
Vlad Matei, M.D.
Board Certified Ophthalmologists
Fellowship-Trained Vitreoretinal Surgeons

☐ New Patient ☐ Established Patient

Patient Full Name	DOB	
Preferred Pronoun: ☐ She/her ☐ He /him ☐ They/them ☐ Prefer no pronoun ☐ Other		
Billing Address	City	Zip
Home Phone | Mobile	Email	
Preferred Name	Marital Status	
Name of Insurance Policy Holder (or self)	DOB of Insurance Policy Holder	
Emergency Contact Name	Relationship to Patient	
Emergency Contact Home Number	Emergency Contact Mobile Number	
Referring Doctor or Optometrist's Name	Primary Care Physician's Name	
Reason for today's visit?		
Who may we thank for referring you?		
Please list any medication you're currently taking:		
Do you have any allergies to medications or substances?		
Preferred pharmacy and cross street:		

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye. Dilating drops frequently blur vision for a variable length of time and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. Driving may be difficult immediately after an examination, so we encourage you to make arrangements not to drive yourself.

Adverse reaction, 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 personnel at Rocky Mountain Retina Associates to administer dilating eye drops. I understand the drops are necessary to diagnose my condition.

____ ____________________

Patient Signature (or person authorized to sign for patient) Date

Rocky Mountain Retina Associates | Boulder | Denver | Longmont | Fort Collins
Phone: 303.900.8507 Fax: 303.578.7823

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INSURANCE AND PATIENT BILLING POLICIES

I certify that I have insurance coverage with _________________________________
(name of the insurance company)

I hereby authorize payment of medical benefits and reimbursements **to Rocky Mountain Retina Associates** for all services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance.** I authorize the use of my signature on all insurance claims and the release of any information necessary to process claims.

I understand that Rocky Mountain Retina Associates will consider my patient services related accounts to be delinquent 60 days after they have been notified by the insurance company. If payment or other arrangements has not been made, my account may be forwarded to a collection agency. At that time, I will be charged a $25.00 collection fee and I will be responsible for all additional collection costs, court costs and attorney's fees required for collections associated with my patient services account.

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Patient's Printed Name

_______________________________________ ____________________
Patient Signature (or person authorized to sign for patient) Date

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HIPAA
Consent for use and Disclosure of Health Information for Treatment, Payment, and/or Healthcare Operations

I understand that I have certain rights to privacy regarding my protected health information.

I understand that as part of my health care, Rocky Mountain Retina Associates originates and maintains paper and/or electronic records describing my health history/symptoms, examinations and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis, treatment, and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand that I have the rights and privileges:

- The right to review the notices prior to signing this consent
- The right to object to the use of my health information for directory purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care options

I understand that Dr. Geeta Lalwani or Dr. Vlad Matei are not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I wish to have the following restrictions to the use or disclosure of my health information:

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I understand that as part of the organization's treatment, payment or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept the term of this consent.

____ ____________________

Patient Signature (or person authorized to sign for patient) **Date**