



Welcome to Boulder Eye Surgeons!

Donald J. Keller, MD Brian E. Nichols, MD PhD

Patient Information			
Name:	Social Security #:	Birth Date:	Male Female
Address:		City, State, Zip:	
Email Address:	Home Phone:	Day Phone:	Married Single Minor Other:
Primary Care Doctor:		Referring Doctor:	
If referred, did you bring a referral from your doctor? Yes No If no, where is the referral?:			
Primary Card Holder (if different from patient)			
Name:	Social Security #:	Birth Date:	Male Female
Address:		City, State, Zip:	
Employer:	Home Phone:	Day Phone:	Mother Father Guardian Other:
Parents' Names (if patient is a minor)			
Mother:		Father:	

FINANCIAL POLICY FOR BOULDER EYE SURGEONS

Your insurance policy is a contract between you and your insurance company. We are not a party of that contract, and are unaware of your possible benefits. Please be aware that some, perhaps all, of the services provided may be non-covered services under your contracted plan, and you will be fully responsible for the payment.

Dr. Keller and Dr. Nichols are medical/surgical doctors, so we participate with most medical insurances. However, most of these plans DO NOT cover routine eye exams. If there is a medical condition found during your exam, your insurance company will be billed according to that medical diagnosis. Once filed with your insurance company, we are unable to change the codes, as this would be insurance fraud and is illegal.

We do not participate with any of the "routine" vision plans (i.e. VSP, CVC, DAVIS, etc.). If your medical insurance has vision benefits through a third-party carrier, you will be responsible for the charges at the time they are rendered. Since most medical plans do not cover contact lenses, fitting fees, or any other associated costs are your responsibility and we require these to be paid at the time services are rendered. We will be glad to give you a copy of the bill so that you may submit it for reimbursement.

I hereby authorize release of any information including the diagnosis and the records of any treatment or examination rendered to me or my dependant or child during the period of such cared to third party payors and/or health care providers.

I authorize and request payment of insurance benefits otherwise due me directly to Boulder Eye Surgeons, PC.

I acknowledge receipt of Notice of Privacy Practices (HIPAA) from Boulder Eye Surgeons.

I UNDERSTAND THAT IT IS MY RESPONSIBILITY:

1. To provide the office with a current insurance card and active credit card.
2. Payment will be made at the time of service if I do not have my insurance card with me.
3. I understand that my credit card will be charged after the insurance company has processed my claim, for the amount for which I am responsible.
4. I understand that I am financially responsible for any charges that are not covered by my health insurance plan or for any balance due following insurance payment. Co-payments are due at the time of the visit as is full payment for non-insured patients. I understand that I am responsible for any legal and/or collection fees should my account become past due.

Signature: _____ Date: _____

(Patient/Responsible Party)