Jason M. Jost, O.D. Kristen Worthen, O.D.

New Patient Registration

Welcome to Pikes Peak Eye Care! Thank you for choosing us for your eye care needs. We are committed to providing the best and most comprehensive care possible. Please take a moment to complete the following information.

Personal Information:

Patient Name: _____ Today's Date: _____

Date of Birth: _____ Gender:_____ Social Security Number: _____

Phone: Home_____ Cell:_____ Work:_____

Email (for appointment reminders and newsletters): _____

Communication Preference (Check one): Phone_____ Text_____ Email_____ Postal Mail_____

Street Address: _____ Apt/Lot #_____

City: _____ State: _____ Zip Code: _____

Employer's Name: _____ Occupation: _____

Preferred Language: _____ Race: _____ Ethnicity: _____

Parent/Guardian's Name (if under 18): _____

Parent/Guardian's Primary Phone Number: _____

Are you a hospice care patient? Yes_____ No_____

Emergency Contact: _____ Phone: _____

Relationship to Patient: _____

PIKES PEAK
EYE CARE

To best protect our staff, patients, and community, please fill out the following form to be reviewed for your appointment today.

Do you have any of the following symptoms?	YES	NO
Cough		
Shortness of Breath		
Fever		
Chills/Shaking		
Fatigued/Run Down		
Headache		
Loss of taste or smell		
Sore Throat		
Muscle Aches/Pains		

Have you been exposed to a COVID-19 positive patient? And if yes, when?

_____

_____

Is anyone in your family ill? No _____ Yes _____ Please Explain _____

_____

Patient Name: _____

Patient Signature: _____ Date: _____

Financial Policy

Eye Care Services: Our office provides a full scope of eye care services including routine vision care (ie: check-ups, glasses and contact lenses), as well as medical eye care services (ie: treatment and evaluations for allergies, dry eye, traumas, diseases, cataracts, glaucoma, and macular evaluation.) Depending on the nature of your visit, we may be able to bill your vision plan, your medical insurance or both. Please present all your insurance information to the receptionist upon arrival.

Professional Service Policies: Our follow up visits are intended to assess ocular health after treatment has been initiated. While the follow up appointment is in conjunction with an initial visit it is still considered a thorough evaluation of the current condition and will be billed as its own appointment.

Payment: Full payment is due at time of service. We accept Cash, Check, Visa, MC, Discover, AmEx, or Care Credit.

Signature Authorization: I request payment of authorized medical insurance benefits be made either by myself, or on my behalf for any services furnished to me by the staff and doctors affiliated with Pikes Peak Eye Care. ***I understand that I am responsible for any procedures not covered by my insurance company for any reason. I understand that I am responsible for any co-payments, deductibles and /or contact lens fittings.***

I authorize the release of any medical information to the authorized third party necessary to process claims for services rendered.

I understand and agree to the above terms of payment. I understand that if I fail to make my payments, my account may be turned over to a collection agency. I understand and agree to pay reasonable attorney and/or collection fees accrued should my account become delinquent.

Patient Name (Printed) _____ Date_____

Patient Signature (or Parent/Guardian)_____

Privacy Policy Acknowledgment

HIPAA Privacy Acknowledgment of Notice of Privacy Practices: I acknowledge that all information in my medical records is confidential and will be handled only by the associates of Pikes Peak Eye Care.

Patient Signature (or Parent/Guardian) _____ Date _____