

**InSight**

RETINA CONSULTANTS, P.C.

Diseases & Surgery of the Retina & Vitreous

Dennis J. O'Connell, D.O.

Aurora • Boulder • Edwards • Glenwood Springs

15901 E Briarwood Circle • Suite 100  
Aurora, CO • 80016

P. 303.662.8400 1.877.283.5807 F. 303.662.8677  
Info@InSightRetina.com www.InSightRetina.com

## Patient Information

**Patient's Name Mr. Mrs. Ms.**

Date:

Social Security#:

Birthdate:

Gender:  Male  Female

Home Phone:

Best phone number for you during the day:

Mailing Address: Street/PO Box

City State Zip

Email Address:

May we contact you by Email?  Yes  No  
(Please initial your permission): \_\_\_\_\_

Text Messaging (Cell phone#):

May we contact you by Text?  Yes  No  
(Please initial your permission): \_\_\_\_\_

Referred By:

Optometrist:

Primary Care Physician:

Emergency Contact's Name

Phone (other than home phone number)

Contact's Relationship to patient:

**If you mark yes to either of the below, please inform the receptionist for additional forms.**

**Is your condition a work related injury?  Yes  No**

If your condition is "work related", please provide the following information:

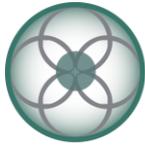
Employer:

Employer's Address: Street

City

State

Zip



**InSight**

RETINA CONSULTANTS, P.C.

Diseases & Surgery of the Retina & Vitreous

Dennis J. O'Connell, D.O.

Aurora • Boulder • Edwards • Glenwood Springs

15901 E Briarwood Circle • Suite 100  
Aurora, CO • 80016

P. 303.662.8400 1.877.283.5807 F. 303.662.8677  
Info@InSightRetina.com www.InSightRetina.com

Is your condition Automobile related?  Yes  No

### Medical Insurance Information

\_\_\_\_\_  
Primary Insurance:

\_\_\_\_\_  
Secondary Insurance:

\_\_\_\_\_  
Policy Holder:

\_\_\_\_\_  
Policy Holder:

\_\_\_\_\_  
Policy Holder's ID#:

\_\_\_\_\_  
Policy Holder's ID#:

\_\_\_\_\_  
Policy Holder's DOB:

\_\_\_\_\_  
Policy Holder's DOB:

\_\_\_\_\_  
What is your relationship to the policy holder?

**MEDICARE PATIENTS ONLY:**

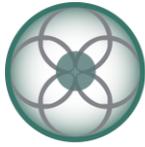
Do you or your spouse work?  Yes  No

If Yes: \_\_\_\_\_

Employer's Name:

\_\_\_\_\_  
Supervisor's Name:

\_\_\_\_\_  
Employer's Phone Number:



**InSight**

RETINA CONSULTANTS, P.C.

Diseases & Surgery of the Retina & Vitreous

Dennis J. O'Connell, D.O.

**Aurora • Boulder • Edwards • Glenwood Springs**

**15901 E Briarwood Circle • Suite 100  
Aurora, CO • 80016**

**P. 303.662.8400 1.877.283.5807 F. 303.662.8677  
Info@InSightRetina.com www.InSightRetina.com**

**AUTHORIZATION AND RELEASE:**

As a member of an insurance plan, I am aware that I am required to bring my insurance card and obtain a referral, if necessary, in order to receive benefits for specialty care from insight Retina. If I do not have a valid referral or authorization from my insurance company, I understand I am fully responsible for all charges incurred.

I hereby authorize payment of all benefits to Insight Retina for services rendered. I authorize the release of any medical information necessary to process this claim and all future claims. I authorize the use of this signature on all insurance submissions. I agree that I am responsible for all co-payments, deductibles, co- insurance, non-covered services, and amounts exceeding any maximum benefits outlined by my insurance plan.

I understand that in the event my insurance company does not pay for services rendered by Insight Retina, I agree to accept full financial responsibility for any direct or ancillary charges for services rendered in behalf of myself and/or my dependents.

---

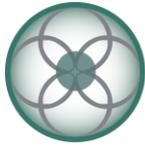
Patient's Signature:

Date:

---

Front Desk Signature:

Date:



**InSight**

RETINA CONSULTANTS, P.C.

Diseases & Surgery of the Retina & Vitreous

Dennis J. O'Connell, D.O.

Aurora • Boulder • Edwards • Glenwood Springs

15901 E Briarwood Circle • Suite 100  
Aurora, CO • 80016

P. 303.662.8400 1.877.283.5807 F. 303.662.8677  
Info@InSightRetina.com www.InSightRetina.com

## Health History

Patient's Name **Mr. Mrs. Ms.**

Date of birth:

Allergies:

Surgeries in the last 5yrs:

Are you pregnant or do you think you might be?  Yes  No

Primary Care Physician:

### PLEASE CIRCLE "YES" OR "NO" FOR THE FOLLOWING:

Social Drug Use:	Yes	No			
Alcohol:	Yes	No			
Tobacco Use:	Yes	No		How many/day:	
Diabetes:	Yes	No	How Long:	Medication/mg:	
High Blood Pressure:	Yes	No	How Long:	Medication/mg:	
Heart Disease:	Yes	No	How Long:	Medication/mg:	
Cancer:	Yes	No	How Long:	Medication/mg:	
Arthritis:	Yes	No	How Long:	Medication/mg:	
Thyroid:	Yes	No	How Long:	Medication/mg:	
Lung Disease:	Yes	No	How Long:	Medication/mg:	
Cholesterol:	Yes	No	How Long:	Medication/mg:	
Glaucoma:	Yes	No	How Long:	Medication/mg:	
Cataracts:	Yes	No	How Long:		



**InSight**

RETINA CONSULTANTS, P.C.

Diseases & Surgery of the Retina & Vitreous

Dennis J. O'Connell, D.O.

Aurora • Boulder • Edwards • Glenwood Springs

15901 E Briarwood Circle • Suite 100  
Aurora, CO • 80016

P. 303.662.8400 1.877.283.5807 F. 303.662.8677  
Info@InSightRetina.com www.InSightRetina.com

Do you wear contacts? Yes No How Long: \_\_\_\_\_ Hard or Soft: \_\_\_\_\_

Is there a family history of any of the above diseases?  Yes  No

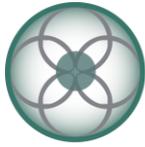
If yes, with  Parents  Siblings

Which Disease(s)? \_\_\_\_\_

List any other medical condition(s) you may have. \_\_\_\_\_

Please list any other prescription medications you take. \_\_\_\_\_

What vision difficulties are you having (blurry vision, floaters)? \_\_\_\_\_



**InSight**

RETINA CONSULTANTS, P.C.

Diseases & Surgery of the Retina & Vitreous

Dennis J. O'Connell, D.O.

Aurora • Boulder • Edwards • Glenwood Springs

15901 E Briarwood Circle • Suite 100  
Aurora, CO • 80016

P. 303.662.8400 1.877.283.5807 F. 303.662.8677  
Info@InSightRetina.com www.InSightRetina.com

## NO SHOW POLICY

This policy is in effect for all appointments scheduled. If you do not show up to an appointment or cancel your appointment within 24 hours you will be charged a fee of \$30.00 for the missed appointment. We do take into consideration the weather and other life events, so in those cases we are lenient with the 24 hours notice.

Please sign below after reading the above policy.

---

PRINT NAME:

DATE:

---

SIGNATURE:



**InSight**

RETINA CONSULTANTS, P.C.

Diseases & Surgery of the Retina & Vitreous

Dennis J. O'Connell, D.O.

Aurora • Boulder • Edwards • Glenwood Springs

15901 E Briarwood Circle • Suite 100  
Aurora, CO • 80016

P. 303.662.8400 1.877.283.5807 F. 303.662.8677  
Info@InSightRetina.com www.InSightRetina.com

## HIPAA (Health Information Portability and Accountability Act of 1996)

### Summary of Notice of Privacy Practices

**Uses and Disclosures of Health Information.** We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other healthcare providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment.

**Uses and Disclosures Based on Your Authorization.** Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

**Uses and Disclosures NOT Requiring Your Authorization.** In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and safety;
- To government agencies for the purposes of their audits, investigations and other oversight activities;
- To government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and as otherwise required by law.

**Consent to Communicate Medical Results:**

(Please Circle Below)

Authorization to leave a message/results at **home**:

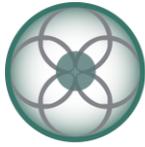
Yes No Phone#: \_\_\_\_\_

Authorization to leave a message/results at **work**:

Yes No Phone#: \_\_\_\_\_

Authorization to leave a message/results on **cell**:

Yes No Phone#: \_\_\_\_\_



**InSight**

RETINA CONSULTANTS, P.C.

Diseases & Surgery of the Retina & Vitreous

Dennis J. O'Connell, D.O.

15901 E Briarwood Circle • Suite 100  
Aurora, CO • 80016

P. 303.662.8400 1.877.283.5807 F. 303.662.8677  
Info@InSightRetina.com www.InSightRetina.com

Aurora • Boulder • Edwards • Glenwood Springs

Persons with whom InSight Retina Consultants, PC, **may discuss** my medical condition, test results, billing issues and/or schedule appointments are named below:

(Please Circle Below)

Spouse: \_\_\_\_\_ Authorization: Yes No Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

**Patient Rights.** As our patient, you have the following rights:

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive notices of our privacy practices.

If you have a question, concern, or complaint regarding our privacy practices, please contact the office for a complete Notice of Privacy Practices.

Please sign below after reading the above policy.

\_\_\_\_\_  
PRINT NAME:

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

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

\_\_\_\_\_  
For more information about HIPAA or to file a complaint, contact:

The US Department of Health and Human Services  
Office of Civil Rights  
200 Independence Avenue, S.W.  
Washington, D.C. 20201  
(202) 619-0257 or Toll Free (877) 696-6775