Western Rockies Eye Center
2460 Patterson Road, Unit 2
Grand Junction, CO 81505
(970) 243-9000

Western Rockies Eye Center, P.C.

Gregory E. Kellam, M.D.
Tracy D. Carter, D.O.
Michael E. Luby, O.D.

NAME_____

MALE_____ FEMALE_____ DATE OF BIRTH____/____/____ SS#____-___-_____

PRIMARY PHONE#_____ OK TO LEAVE MESSAGE YES___NO____

CELL PHONE#_____ WORK PHONE#_____

MAILING ADDRESS_____

CITY _____ STATE_____ ZIP_____

NAME OF SPOUSE_____ PHONE#_____

EMERGENCY CONTACT_____ PHONE#_____

EMPLOYER_____

E-MAIL ADDRESS_____

PRIMARY INSURANCE CARRIER_____MEMBER ID#_____

POLICY HOLDER (SUBSCRIBER NAME)_____

SELF____ SPOUSE____CHILD____ OTHER____ DATE OF BIRTH____/____/_____

SECONDARY INSURANCE CARRIER_____MEMBER ID #_____

POLICY HOLDER (SUBSCRIBER NAME)_____

SELF____SPOUSE____CHILD____OTHER____ DATE OF BIRTH____/____/_____

I request that payment of authorized medicare and /or commercial insurance be made on my behalf to this office for any services furnished by the physician to me. I authorize that any holder of medical information about me, may release to the above listed insurance and its agents any information needed to determine these benefits or the benefits payable for related services.

AUTHORIZED SIGNATURE_____ DATE__/__/____

This signature authorizes the physician to file to the insurance on my behalf

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PLEASE COMPLETE ALL OF THE FOLLOWING INFORMATION AND BRING TO YOUR APPOINTMENT

Date: _____

Name: _____

DOB: _____

Family Physician: _____

Current Medications/Vitamins/ Reason for Use Dosage/Frequency

Continue on back of sheet if needed

Drug Allergies and Reaction:

All Major Surgeries and Date

Eye Surgery/Laser Eye Surgery and Date

Date of Last Eye Exam _____

Alcohol Use? Y N

How Much? Per day _____

OR Per week _____

Tobacco Use? Y N

Family Eye History			**Relationship**
Blindness	Y	N	_____
Glaucoma	Y	N	_____
Macular Degeneration	Y	N	_____
Retinal Detachment	Y	N	_____
Diabetic Retinopathy	Y	N	_____
Crossed/Lazy Eye	Y	N	_____

WRITTEN ACKNOWLEDGEMENT FORM

I am a patient of Western Rockies Eye Center. I hereby acknowledge receipt of Western Rockies Eye Center's Notice of Privacy Practices.

Name (please print): _____

Signature: _____

Date: _____

OR

I am a parent or legal guardian of _____. I hereby acknowledge receipt of Western Rockies Eye Center's Notice of Privacy Practices with respect to the patient.

Name (please print): _____

Relationship to Patient (please circle one): Parent Legal Guardian

Signature: _____

Date: _____

Western Rockies Eye Center, P.C.

INSURANCE / BILLING POLICIES

Western Rockies Eye Center participates with many different insurance companies for medical benefits. It is the patient's responsibility to make sure the doctor you are scheduled with is a participating provider with your specific insurance plan.

- Patients are required to bring all insurance cards including **MEDICARE** cards with you to your appointment. Western Rockies Eye Center is unable to bill insurance without an up to date scan of your insurance card(s). Unauthorized vison plans and insurance plans we are unaware of will not be re-billed after your visit.

- Refractions, the portion of the exam that determines the correction for glasses is not covered by most insurance companies. If you choose not to have a refraction done, please inform the technician at the start of your exam.

- All co-pays, deductibles, co-insurance, refractions and self-pay totals are due at the time of service.

- The business office will contact insurance companies on claims unpaid after 30 days to check the status. On occasion we may need assistance for payment.

- Unpaid claims past 90 days become patient's responsibility.

- Monthly statements will be sent when a balance is owed. Balance is due within 30 days of service. Once an account reaches 90 days past due it will be turned over to an outside collection agency. All collection fees are the patient's responsibility. Once an account has been placed into collections the patient is dismissed from our practice and will need to transfer care to another office.

VISION PLANS

Western Rockies Eye Center participates with select vision plans. **ALL VISION INSURANCE PLANS REQUIRE AUTHORIZATION BEFORE YOUR APPOINTMENT.** It is the responsibility of the patient to make sure the doctor you are seeing is a participating physician with your plan and to provide plan information so we may obtain proper authorized before your visit. **If you are being followed for or are diagnosed with a medical issue your vision plan may require medical insurance to be billed.**

OPTOMETRIST

Dr.Luby assists patients with fitting and dispensing of contact lenses and patients requiring routine exams. **MOST** insurance companies do **NOT** cover contact lens fitting fees or contact lenses.

Please feel free to call with any questions 970-243-9000.

I have read, understand and agree to the policies of Western Rockies Eye Center.

_____

Signature Date