HIGH COUNTRY MACULA

MICHAEL S. SELIGSON, MD, FACS
IURI S. GOLUBEV, MD
FRED L. McMILLAN, MD
HENRY L. HUDSON, MD, FACS

New Patient Information

Welcome to High Country Macula, Retina, and Vitreous, PC

Please print: Date _____

Name _____ Social Security No. _____

☐ Male ☐ Female ☐ Other identity _____ ☐ Straight ☐ Gay or Lesbian ☐ Other _____

Date of Birth _____ Age _____ Phone _____

Address _____

City _____ State _____ Zip _____

Referring Doctor _____ Phone _____

Address _____

Family Doctor _____ Phone _____

Address _____

Occupation _____ Employer _____ Phone _____

Address _____

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Domestic Partnership

Spouse _____ Social Security No. _____

Date of Birth _____ Age _____ Phone _____

Address _____

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New Patient Information

Emergency Contact _____ Relationship _____ Phone _____

Address _____

Insurance Co. _____ Group No. _____ Member No. _____

Please complete if under 18 years of age or if a student:

Father _____ D.O.B. _____ Phone _____

Employer _____ Social Security No. _____

Address _____

Mother _____ D.O.B. _____ Phone _____

Employer _____ Social Security No. _____

Address _____

FINANCIAL ASSIGNMENT AND AGREEMENT: High Country Macula, Retina, and Vitreous, PC is committed to seeing every patient who has need. It is important to us that all patients receive appropriate care. However, we are required to charge each patient our set fees regardless of whether or not our patient has insurance. We will work with each uninsured patient on an individual basis to set up a reasonable payment plan if he or she does not have the means to pay for the entire visit at the time of service. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and not a substitute for payment. It is each patient's responsibility to pay any deductible amount, co-insurance, or any non-covered service not paid for by his or her insurance.

I request payment of authorized insurance benefits be made on my behalf for any services furnished to me by High Country Macula, Retina, and Vitreous, PC. I authorize High Country Macula, Retina, and Vitreous, PC and its agents to review my medical information to determine these benefits and the benefits assigned. A copy of this Assignment and Agreement shall be considered as valid as an original. I hereby authorize High Country Macula, Retina, and Vitreous, PC to release all information necessary to secure payment. I further understand that I am ultimately responsible for ensuring that all payments are made.

Signed (patient or parent if minor): _____ Date _____