Patient Responsibility

I understand and agree that I am financially responsible for all charges for any all services rendered. This includes any medical service or visit, routine examination, refraction, testing, and any other services or screening ordered by the doctor or staff.

I understand that while my insurance may confirm my benefits, confirmation of benefits is not a guarantee of payment and that I am responsible for any unpaid balance.

I understand and agree that it is my responsibility to know if my insurance requires a referral from my primary care physician and that it is up to me to obtain the referral. I understand that without this referral, my insurance will not pay for any services and that I will be financially responsible for all services rendered.

I agree to inform the office of any changes in my insurance coverage. If my insurance has changed or is terminated at the time of service, I agree that I am financially responsible for the balance in full.

If I am a Medicare patient, I understand that I need to provide the office both my Medicare ID and my secondary ID card. If the office does not have the proper information for a secondary insurance, the secondary will not be billed. It will be my responsibility to pay the balance and then file a claim with the secondary for reimbursement.

By signing this form, I consent to the use and disclosure of protected health information about me for treatment, payment and health care options, and/or as required by law. I have the right to revoke this consent, in writing, signed by me. However, such revocation shall not affect any disclosures already made in compliance with my prior consent. Boulder Biologics provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

_____ _____ _____

Printed Patient Name (Guardian if applicable) Patient or Guardian Signature Date

I give permission to communicate my Private Healthcare Information to:

_____ _____

Name Relationship

_____ _____

Name Relationship

_____ _____

Name Relationship