PATIENT INFORMATION

Please provide all requested information- Please print

Last Name:_____ First Name:_____ DOB:____/_____/____ Sex: M F

Address:_____ City:_____ State:_____ Zip:_____

Telephone: (_____)_____ Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

Email:_____ Preferred method of contact: ☐ Email ☐ Postal ☐ Telephone

SSN:_____ Employer:_____

Race: ☐ American Indian/Alaska Native ☐ Asian
☐ Black/ African American ☐ Hispanic
☐ Native Hawaiian/Pacific Islander ☐ White

Ethnicity: ☐ Hispanic/Latino
☐ Not Hispanic/Latino
☐ Native Hawaiian/Pacific Islander

Is the patient the Responsible Party? ☐ YES ☐ NO (If no, please fill out responsible party information)

Responsible Party: _____ Relationship:_____

DOB:____/_____/_____ Sex: M F SSN:_____ Telephone:_(_____)_____

Address:_____ City:_____ State:_____ Zip:_____

Employer:_____ Employer Phone: _(_____)_____

Referring/Primary Care Physician:_____

Emergency Contact:_____ Telephone: (_____)_____

During the course of your examination, the doctor may find medical diagnoses that require additional tests. The fees for these are often covered by medical insurance. Please provide your medical insurance, even if you are not having a medical examination today.

Medical Insurance: _____Policy Number:_____ Group Number:_____

Policy Holder:_____ DOB:____/____/____ Relationship:_____

Vision Insurance: _____Policy Number:_____ Group Number:_____

Policy Holder:_____ DOB:____/____/____ Relationship:_____

EMAIL -STANDARD OPTICAL PROTECTS YOUR E-MAIL INFORMATION AND NEVER SELLS OR RELEASES THIS INFORMATION TO THIRD PARTIES WITHOUT YOUR CONSENT. WE RESERVE THE RIGHT TO USE YOUR EMAIL FOR THE FOLLOWING, BUT NOT LIMITED TO: APPOINTMENT REMINDERS, PRODUCT COMPLETION NOTIFICATION, INSURANCE REGISTRATION AND UPDATES, BILLING AND/OR PAYMENT MATTERS, TREATMENT AND FOLLOW-UP CARE INSTRUCTIONS, EYE CARE AND HEALTH CARE RELATED MARKETING

X_____
Patient Initials authorizing use of email

THIS OFFICE WILL PROVIDE INSURANCE BILLING SERVICES FOR YOU. REMEMBER THAT YOU ARE ULTIMATELY RESPONSIBLE FOR ANY CHARGES INCURRED IN THIS OFFICE. IT IS YOUR LEGAL RESPONSIBILITY TO PAY ANY DEDUCTIBLE AMOUNT, CO-INSURANCE, AND OR ANY OTHER BALANCES NOT PAID BY YOUR INSURANCE CARRIER.

I ACKNOWLEDGE BY MY SIGNATURE THAT I HAVE READ THE "CONDITIONS OF SERVICE" AND "FINANCIAL AGREEMENTS" ON THE REVERSE SIDE AND AS THE PATIENT, THE PATIENT'S AUTHORIZED REPRESENTATIVE, OR GENERAL AGENT FOR THE PURPOSE OF SIGNING THIS DOCUMENT, HEREBY ACCEPT THOSE TERMS.

X_____/____/____/____ _____/____/____/_____

Patient or Agent Signature Date Witness Signature Date

STANDARD OPTICAL CONDITIONS OF SERVICE

1. CONSENT TO TREATMENT: I hereby consent to any laboratory procedures, medical treatment or facility service rendered to the patient under the general and special instructions of the attending physician.

2. RELEASE OF INFORMATION: Subject to State and Federal regulations (42 C.F.R. part II), this facility and/or Physician Billing Service may disclose all or any part of the patient's record for this service to any person or corporation which is or may be liable under a contract to the physician, or to a family member or employer of the patient for all or part of the provider's charges, including, but not limited to hospital or medical service companies, insurance companies, worker's compensation carriers, welfare funds, and all authorized auditors as specified in the insurance Carrier Guidelines and referring professionals.

3. FINANCIAL AGREEMENTS: I hereby certify that the information provided herein is correct. I understand that I am responsible for full payment of all charges incurred with the service and I agree to make full payment for such charges by cash and/or payment from assigned insurance benefits. I understand that all charges not covered by insurance are due in full at time of service. In the event that full payment for charges incurred (above) are not made as agreed upon (above), I agree to pay delayed payment fees at the rate of 1½% per month (18% per year) on any unpaid balance and to pay all costs and expenses incurred in collection of said charges, including reasonable attorney's fees and collection expenses. I hereby consent and submit to the jurisdiction and venue of the courts of the State of Utah, County of Service, for the purpose of such action.

In the event that my insurance does not fully cover billed services, I understand I will be held responsible for any outstanding amount that is not covered.

4. MEDICARE/MEDICAID PATIENT'S CERTIFICATION: I certify that the information given by me in applying for payment under Titles XVIII and XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed to process any claim on this or any related service. I request that payment of authorized benefits be made in my behalf directly to this facility and/or Physician Billing Service for its charges and for any charges of Physicians for whom the facility is authorized to bill in connection with its services.

5. CHAMPUS/CHAMPVA AUTHORIZATION: I request payment of authorized benefits to this facility on my behalf for any services furnished me by this facility including Physician Billing Service I authorized to bill in connection with its services.

6. RELEASE OF INFORMATION: I hereby authorize above named facility to release to my insurance company any information concerning procedures performed during this treatment and the final diagnosis, as well as information contained on this form.

7. ASSIGNMENT OF BENEFITS: I hereby assign and transfer to this facility and/or Physician Billing Service all insurance benefits payable to me by my insurance company(s) (and other policies, if any) for services and costs incurred in connection with this service. I understand the assignment of benefits shall be exclusively for the payment of charges for the service. I understand and authorize payment of such benefits shall be made by my insurance company to the facility and/or Physician Billing Service. I understand that I am financially responsible for charges not covered or paid by my third party sponsor, which may include, but are not limited to: telephone calls, reports requested by the patients, insurance carriers, or employers and appointments not cancelled at least 24 hours in advance.

8. RECEIPT AND ACKNOWLEDGMENT OF PRIVACY PRACTICES: I hereby declare that I have read and understand the facility's Policy of Privacy Practices.

9. RELEASE OF ACCOUNT INFORMATION: I understand any individual listed on the front of this page and any individual, who can be reasonably assumed to be authorized, will be permitted to retrieve any and all information pertaining to this account. This can include, but is not limited to, medical information relating to any person listed on the account as well as financial information and transactions. Furthermore, if there are individuals whom I do not want authorized to access information, I will notify the facility HIPAA Compliance officer in writing.

10. REFRACTION: A refraction is a test used to determine a patient's lens prescription to correct their vision. This is an additional fee that your insurance may or may not cover.

11. CONTACT LENS FITTING: A contact lens fitting is necessary if the patient desires a contact lens prescription. This charge will be in addition to the eye exam fee. Contact lens fittings vary in price and the fee is dependent on the complexity of the contact lenses worn.

PERSONAL HEALTH INFORMATION

Please provide all requested information- Please print

Last Name:_____ First Name:_____ Today's Date:____/____/_____

Date of Birth:____/____/____ Sex: ☐Male ☐Female Height:_____feet _____inches Weight:_____pounds

Reason for the patient's visit (chief complaint): _____

When and where was the patient's last eye exam?_____

VISUAL/OCULAR SYMPTOMS: Check ☑ Yes (Y) for any applicable symptoms below.

	Y		Y		Y		Y	
Poor Vision		Tearing		Loss of Vision		Spots, Floaters		Other:
Eye Pain		Redness		Flashes of Light		Double Vision		

REVIEW OF MEDICAL HISTORY: Check ☑ Yes (Y) for applicable conditions

Has the patient ever experienced symptoms of, been diagnosed with, or received treatment for the following conditions?
If yes, provide information below.

	Y		Y		Y		Y
Alzheimer's		Autoimmune Disease		Heart Disease		Migraine	
Anemia		Cancer Type: _____		Hearing Loss		Parkinson's Disease	
Anxiety		Dementia		High Blood Pressure		Thyroid Disease (hyper / hypo thyroidism)	
Arthritis Rheumatoid Y / N		Depression		High Cholesterol		Seizure/Epilepsy	
Asthma		Diabetes (type I or II) Diagnosis Date: _____		HIV/AIDS		Stroke	

REVIEW OF OCULAR HISTORY: Check ☑ boxes for applicable conditions

Has the patient ever experienced symptoms of, been diagnosed with, or received treatment for the following conditions?
If yes, mark which eyes were affected.

	Affected Eyes		Affected eyes		Affected eyes
Allergies	☐Both	Diabetic Retinopathy	☐L ☐R	Macular Degeneration	☐L ☐R
Amblyopia	☐L ☐R	Dry Eye	☐L ☐R	Keratoconus	☐Both
Cataract	☐L ☐R	Glasses	☐Both	Retinal Tear / Detachment	☐L ☐R
Contact Lenses	☐L ☐R	Glaucoma	☐L ☐R	Eye Turn/Strabismus	☐L ☐R

Please explain any 'yes' answers above:_____

_____

List all other major illnesses and injuries (eye and other): ☐**NONE** _____

_____

_____

List any surgeries that the patient has had (eye and other): ☐**NONE** _____

_____

Is the patient **pregnant**? ☐Yes ☐No **Nursing**? ☐Yes ☐No

MEDICATIONS

List **ALL** medications that patient is currently taking including over-the-counter, or provide staff with any medications list: ☐ **NONE**

_____

_____

_____

ALLERGENS: List all **medication allergies.** ☐ **NONE** Then list any **environmental** or **food allergies**. ☐ **NONE**

Medication:	Reaction:	Allergen:	Reaction:

SOCIAL HISTORY: Check ☑ Yes (Y) or No (N) for the following questions. If yes, check all details that apply.

Has the pt used or participated in:	Y	N	If yes, please check all that apply
Tobacco			☐Cigarette ☐Tobacco ☐Cigar ☐Every day ☐Some days ☐Former
Illicit Substances			
Alcohol			☐Less than 1 drink a day ☐1-2 drinks per day ☐3 or more drinks per day
Driving			☐Daytime driving ☐Nighttime driving

Occupation & Workplace: _____ ☐ Child/Minor ☐Retired

FAMILY HISTORY: Have any first-degree* blood relatives had the following diseases? Check ☑ for Yes (Y)

*First degree relatives include **only** parents and/or full siblings of the patient

Circle affected individuals**:** M=Mother F=Father S=Sister B=Brother GM=Grand Mother GF=Grand Father

☐ **Adopted OR History Unknown**

Condition	Y	Relationship	Condition	Y	Relationship
Blindness		M F S B GM GF	Arthritis		M F S B GM GF
Cataract		M F S B GM GF	Cancer		M F S B GM GF
Glaucoma		M F S B GM GF	Diabetes		M F S B GM GF
Keratoconus		M F S B GM GF	Heart Disease/Attack		M F S B GM GF
Macular Degeneration		M F S B GM GF	High Blood Pressure		M F S B GM GF
Retinal Detachment		M F S B GM GF	Stroke		M F S B GM GF
Other: _____		M F S B GM GF	Other: _____		M F S B GM GF

CONSENT TO DILATE EYES

A dilated exam is necessary to view and diagnose certain diseases of the eye that go undetected without dilation. Dilation typically lasts 3-4 hours. During this time mild light sensitivity and blurred vision is expected, though not debilitating. Most patients see well enough to drive afterwards; the doctor will determine if you are safe to drive before dilating your eyes.

Please check ONE of the following:

☐Yes, I agree to have eyes dilated **or** follow the doctor's recommendation.
☐No, I would like to reschedule the dilation (within 30 days).
☐No, I understand the above statement and refuse the eye dilation.

Patient or Parent/Guardian Signature: _____

Parent/Guardian must sign if the patient is under 18