Patient Information

Legal Name _____ _____ _____ Date of Birth _____
First M.I. Last

Preferred Name _____ Social Security # _____ Email _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Would you like to receive text message appointment reminders? ❑ Yes ❑ No

Marital Status: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Widowed Sex of Patient: ❑ Male ❑ Female

Patient Employment Status: ❑ Retired ❑ Full-Time ❑ Part-time ❑ Unemployed

Employer _____

Race: ❑ Amerian Indian or Alaska Native ❑ Asian ❑ Black or African American ❑ Middle Eastern or North African
❑ Multiracial ❑ Native Hawaiian or Pacific Islander ❑ White or Caucasian ❑ Decline to Answer

Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Decline to Answer

Primary Language: _____

Primary Care Physician _____ Phone _____

Emergency Contact (relative or friend that is someone NOT living with you)

Name _____ Phone _____ Relationship _____

Spouse Information, if applicable

Name _____ Date of Birth _____ ❑ Male ❑ Female

Social Security # _____ Employment Status: ❑ Retired ❑ Full-Time ❑ Part-time ❑ Unemployed

If the Patient is on Parent's Insurance OR Under 18 Years Old

Full Name of Father _____ SS# _____ DOB _____

Employer _____ Work # _____

Full Name of Mother _____ SS# _____ DOB _____

Employer _____ Work # _____

Who is responsible for payment of this account? _____(Parent or Guardian)

Responsible Party's Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Other _____

Address (if different from patient) _____

City _____ State _____ Zip _____ Phone # _____

♦ PLEASE TURN OVER AND COMPLETE OTHER SIDE ♦

Insurance Information Please fill out completely to accompany a copy of your Insurance Card(s).

Primary Medical Insurance _____ ID# _____

Subscriber's Name _____ Subscriber's Employer _____

Patient Relationship to Subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other _____

Secondary Medical Insurance _____ ID# _____

Subscriber's Name _____ Subscriber's Employer _____

Patient Relationship to Subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other _____

Primary Vision Insurance ❑ VSP ❑ EyeMed ❑ March Vision ❑ Opticare ID# _____

Subscriber name _____ Date of Birth _____

Last 4 digits of Subscriber's Social Security #_____

Is this a work related injury? If yes, Date of Injury _____ Time of Injury _____

HIPAA

In accordance with the Health Insurance Portability and Accountability Act (HIPAA), I acknowledge that a **"Notice of Privacy Practices"** was made available to me by Mountain View Eye Center.

Signature _____

Assignment of Benefits

I hereby authorize all medical, vision, and/or surgical benefits to which I am entitled through my insurance carrier(s), (including Medicare, Medicaid, private insurance, and any other health/medical/vision plan(s)) to be paid directly to Mountain View Eye Center. I understand that I am financially responsible for any co-pay, coinsurance, deductible, and non-covered service(s).

I hereby authorize Mountain View Eye Center to release any information to my insurance carrier(s), including my diagnoses and treatment(s). This assignment will remain in effect until revoked, by me, in writing.

I hereby consent to receiving manually dialed and auto-dialed calls (which may include artificial or pre-recorded collection or healthcare related messages) to my wireless/cellular number and/or any other telephone numbers provided during any interaction, agreement, or communication with Mountain View Eye Center and/or its affiliates and assignees, including but not limited to any account management/ billing company(ies) or third-party collection agency(ies).

I agree that in the event that a payment is returned for NSF (non-sufficient funds), I authorize Mountain View Eye Center to charge me for the amount of the payment plus a minimum $20.00 processing fee.

If payment in full is not made as required, then in addition to all other amounts that may be due, I agree to pay a collection fee of up to 40% of the principal amount as provided by §12-1-11 of the Utah Code Annotated, and further agree to pay all other costs of collection (whether incurred by Mountain View Eye Center or its assigns) including but not limited to court costs, reasonable attorney fees, and interest (both pre- and post-judgment) at the rate of 1.5% per month (18% per annum).

Patient Signature _____ **Date** _____

(or legal representative / guardian / parent)

Name of legal representative / guardian / parent (if appliable) _____