Patient Information

Legal Name _____ ____ _____ Date of Birth _____
First MI Last

Preferred Name _____ SSN _____ ☐ Male ☐ Female
Address _____ City _____ State ____ Zip _____
Cell Phone _____ Home Phone _____ Email _____
Employer _____ Work Phone _____ ☐ Full-time ☐ Part-time
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other _____

Primary Care Doctor

Primary Care Doctor _____ Phone _____

Spouse Information

Name _____ SSN _____ DOB _____ ☐ Male ☐ Female
Address (if different from patient) _____ City _____ State ___ Zip _____
Cell Phone _____ Home Phone _____ Work Phone _____
Employer _____ ☐ Full-time ☐ Part-time

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

Name _____ Phone _____ Relationship _____

Insurance Information

Primary Medical Insurance _____ ID# _____
Subscriber's Name _____ Subscriber's Employer _____
Subscriber's DOB _____ Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Secondary Medical Insurance _____ ID# _____
Subscriber's Name _____ Subscriber's Employer _____
Subscriber's DOB _____ Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Vision Insurance ☐ VSP ☐ Eyemed ☐ Opticare ☐ Other _____ ID# _____
Subscriber's Name _____ Subscriber's Date of Birth _____
Last 4 Digits of Subscriber's SSN _____

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.

Patient Signature _____

PLEASE TURN OVER AND COMPLETE OTHER SIDE

Assignment of Benefits & Financial Policy

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 $35.00 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 assignees) including by 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** _____

If not signed by patient, Printed Name of Legal Guardian/Representative _____