Patient Information - Under 18 Years Old

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

Preferred Name _____ SSN _____ ☐ Male ☐ Female
Address _____ City _____ State ____ Zip _____
Cell Phone _____ Home Phone _____ Email _____

Primary Care Doctor/Pediatrician

Primary Care Doctor _____ Phone _____

Parent/Guardian Information

Full Name of Parent #1 _____ SSN _____ DOB _____
Address (if different from patient) _____ City _____ State ___ Zip _____
Cell Phone _____ Home Phone _____ Work Phone _____
Employer _____ ☐ Full-time ☐ Part-time
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other _____

Full Name of Parent # 2 _____ SSN _____ DOB _____
Address (if different from patient) _____ City _____ State ___ Zip _____
Cell Phone _____ Home Phone _____ Work Phone _____
Employer _____ ☐ Full-time ☐ Part-time
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other _____

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 _____ Patient Relationship to Subscriber ☐ Child ☐ Other _____

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

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

PLEASE TURN OVER AND COMPLETE OTHER SIDE

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.

Parent/Guardian 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 $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).

Parent/Guardian Signature _____ Date _____

Printed Name of Parent/Guardian _____