

Patient Information Sheet

First Name _____ Middle Initial ____ Last Name _____
Street Address _____ City _____
State ____ Zip _____ Home Phone _____ Work Phone _____
Social Security Number ____ - ____ - ____
Date of Birth ____ / ____ / ____ Age: _____ Sex: M / F
Marital Status _____ Name of Spouse _____
Primary Insurance Company _____
Policy # _____ Group _____
Secondary Insurance Company _____
Policy # _____ Group # _____
Employer _____ Occupation _____
Nearest Relative _____
Relationship _____
Phone Number(s) _____

Parents or Responsible Party If Different from Patient

First Name _____ Middle Initial ____
Last Name _____
Street Address _____ City _____
State ____ Zip _____ Home Phone _____ Work Phone _____
Social Security Number ____ - ____ - ____
Date of Birth ____ / ____ / ____ Age: _____ Sex: M / F

Additional Family Members to be Seen

Name _____ Name _____ Name _____
Birth date _____ Birth date _____ Birth date _____

SIGNATURE

DATE

Medical History Questionnaire

Date

Name

Birth Date

Name of Family Doctor

Reason for eye visit today

REVIEW OF SYSTEMS

Do you have any problems in the following areas? Please click on those that apply.

Constitutional Symptoms

General:

Fever

Fatigue

Weight loss or gain

Eyes:

Loss of vision

Blurred vision

Double vision

Dryness

Redness

Sandy or gritty feeling

Itching, burning

Foreign body sensation

Excess tearing/ watering

Glare/ light sensitivity

Eye pain or soreness

Chronic infection of eye or lid

Tired eyes

ENT (ear, nose, throat, mouth)

Sinus infection

Cough

Heart:

Heart disease

Irregular heart beat

Heart attack

GI / GU

Stomach

Intestinal problems

Ulcers

Kidney

Bladder

Musculoskeletal

Muscle pain

Joint pain/ Arthritis

Integumentary:

Skin

Breast disease

Neurological:

Seizures

Psychiatric:

Depression

Anxiety

Other

Endocrine:

Diabetes

Thyroid disease

Hematological / Lymphatic

Blood disease

Anemia

Lymph nodes

Allergic / Immunologic:

Head allergy symptoms

Seasonal allergy

Hay fever symptoms

Other:

Pregnant

Cancer

Diabetes

Heart attack

High blood pressure

Stroke

Thyroid disease

Other

Physician's signature: _____ Date: _____

Past History:

List any medication you take _____

List all allergic reactions to medications _____

List all major illnesses and injuries _____

List any surgeries you have had _____

Have you had crossed eyes, lazy eye, drooping eyelid, prominent eyes, or any eye surgery?

History reviewed. _____ No changes _____ Additions as noted above

**Salt Lake Eye Associates
1025 East 3300 South #B
Salt Lake City, Utah 84106
(801)281-2020**

LIFETIME SIGNATURE AUTHORIZATION

I UNDERSTAND THAT I AM RESPONSIBLE FOR MY BILL EVEN IN THE EVENT MY INSURANCE DENIES EITHER PART OR ALL OF MY CLAIM.

I UNDERSTAND THAT IF MY INSURANCE COMPANY REQUIRES A REFERRAL BEFORE SERVICES ARE PERFORMED AND IF I DO NOT PROVIDE THAT REFERRAL I AM RESPONSIBLE TO PAY FOR SERVICES.

I AUTHORIZE DIRECT PAYMENT BY INSURANCE COMPANIES TO MY PHYSICIAN AND I RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION FOR TREATMENT TO THOSE INSURANCE COMPANIES.

I FURTHER REQUEST THAT ANY SUPPLEMENTAL INSURANCE BENEFITS FILED IN MY BEHALF BE PAID AS STATED ABOVE.

I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION (HCFA) AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.

I UNDERSTAND THAT SERVICE CHARGES ARE ASSESSED AT 1.5% PER MONTH, WITH A MINIMUM CHARGE OF \$5.00 ON BALANCES 30 DAYS AND OLDER. I AGREE TO PAY ALL INTEREST CHARGES, COLLECTION FEES, AND/OR ATTORNEY'S FEES OR COURT COSTS IF ANY DELINQUENT BALANCE IS PLACED WITH A COLLECTION AGENCY OR ATTORNEY FOR COLLECTION OR SUIT.

I UNDERSTAND THAT CO-PAYS ARE DUE THE DAY OF SERVICE. IF I AM BILLED FOR MY CO-PAY THERE WILL BE AN ADDITIONAL \$10.00 CHARGE ADDED TO MY BILL.

I UNDERSTAND THAT MY EYES MAY BE DILATED IN THE COURSE OF MY EXAM AND THAT AS A CONSEQUENCE I MAY EXPERIENCE TRANSIENT BLURRING OF VISION WHICH MAY MAKE IT DIFFICULT FOR ME TO DRIVE, READ, OR CARRY ON NORMAL VISUAL ACTIVITIES UNTIL THE EFFECT WEARS OFF OR IS REVERSED. ALLERGIC REACTIONS TO THE MEDICATIONS ARE VERY RARE. DARK GLASSES WILL BE PROVIDED AT THE END OF THE VISIT TO PROVIDE COMFORT IN BRIGHT LIGHT. YOU MAY ASK EITHER THE TECHNICIAN OR PHYSICIAN NOT TO DILATE YOUR EYES.

I UNDERSTAND THAT MEDICARE AND MEDICAID DO NOT PAY FOR THE REFRACTION (GLASSES PRESCRIPTION) AND THAT IF THIS SERVICE IS PROVIDED I WILL BE RESPONSIBLE FOR PAYMENT OF THIS SERVICE.

SIGNATURE _____ DATE _____

PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to insure that personal health care information is protected for privacy. The "Privacy Rule" was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment, or health care operation in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with (such as laboratories that only interact with physicians and not patients) and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

As part of our treatment program you will be sent post cards that will remind you that it is time to make an appointment. In addition, as a courtesy to our patients we will call to confirm appointments. We will leave messages if we are not able to contact you directly. You may refuse to consent to the use or disclosure of your personal health information but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you reviewed our privacy notice.

Print Name _____

Signature _____

Date _____

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience aggravation, and money. we want you to know that all of our employees, managers, and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws, and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.

I _____ give my permission for Salt Lake Eye
(print name)

Associates to discuss my health information, treatment, or billing information with the following individuals:

- * Spouse _____
- * Parents _____
- * Siblings _____
- * Children _____

Signature _____ Date _____