THANK YOU FOR CHOOSING THE NORTHERN UTAH EYE CENTER FOR YOUR EYE CARE NEEDS.
WE APPRECIATE THE OPPORTUNITY TO SERVE YOU!

BILLING, INSURANCE AND COMMUNICATION

BILLING AND INSURANCE:

THE NORTHERN UTAH EYE CENTER IS A FEE FOR SERVICE ENTITY. YOUR INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. WE ARE NOT A PARTY TO THAT CONTRACT. AS A COURTESY, WE WILL BILL YOUR INSURANCE. IT IS YOUR RESPONSIBILITY TO CONTACT YOUR INSURANCE COMPANY TO SEE IF WE ARE PROVIDERS FOR YOUR SPECIFIC PLAN(S) AND FIND OUT WHAT THEY WILL OR WILL NOT COVER.

IF YOU WOULD LIKE US TO BILL YOUR INSURANCE, YOU WILL NEED TO PRESENT YOUR INSURANCE CARD AT THE TIME OF SERVICE. IF YOU DO NOT PROVIDE US WITH CORRECT INSURANCE INFORMATION AT THE TIME OF SERVICE, YOU WILL BE RESPONSIBLE FOR THE FULL VISIT CHARGE. PATIENTS ARE ALSO EXPECTED TO PAY ANY BALANCE DUE AND/OR CO-PAYS AT THE TIME OF SERVICE. IF WE BILL YOUR INSURANCE AND THEY SUBSEQUENTLY PAY THEIR PORTION, YOU ARE RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY YOUR INSURANCE COMPANY. ANY AMOUNT NOT COVERED BY YOUR INSURANCE COMPANY IS EXPECTED TO BE PAID WITHIN 30 DAYS. IF THE FULL PAYMENT HAS NOT BEEN RECEIVED WITHIN 90 DAYS OF ALL INSURANCE PAYMENTS BEING PROCESSED, YOUR ACCOUNT WILL BE TURNED OVER TO OUR COLLECTION AGENCY. IF YOUR ACCOUNT IS SENT TO COLLECTIONS, THE UNDERSIGNED AGREES TO PAY AN ADDITIONAL COLLECTION FEE UP TO 40% OF THE UNPAID BALANCE. IN THE EVENT OF A LAWSUIT TO COLLECT THE UNPAID BALANCE THE ADDITIONAL COLLECTION RATE WILL BE 50%. THE UNDERSIGNED FURTHER AGREES TO PAY COURT COSTS AND ATTORNEY'S FEES.

A REFRACTION IS PART OF A COMPREHENSIVE EYE EXAM AND DETERMINES YOUR PRESCRIPTION FOR GLASSES OR CONTACTS. REFRACTIONS MAY NOT BE COVERED BY YOUR INSURANCE. IF YOUR INSURANCE CONSIDERS THIS A NON-COVERED BENEFIT, YOU WILL BE RESPONSIBLE FOR THE $40.00 CHARGE.

THERE WILL BE A $25.00 RETURNED CHECK FEE.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

HIPAA ARE FEDERAL LAWS THAT PROTECT YOUR PRIVACY & HEALTH INFORMATION. WE CANNOT GIVE ANY OF YOUR PERSONAL, HEALTH AND BILLING INFORMATION OUT TO ANYONE EXCEPT YOU, UNLESS YOU SPECIFY WHO YOU WOULD LIKE TO HAVE ACCESS. IF YOU WOULD LIKE A FAMILY MEMBER OR FRIEND TO HAVE ACCESS TO YOUR ACCOUNT, HEALTH, AND PERSONAL INFORMATION PLEASE PROVIDE THEIR NAME, PHONE NUMBER AND RELATIONSHIP TO YOU ON THE LINES BELOW.

NAME:________________________________ PHONE: (   )____________________RELATIONSHIP:________________________

NAME:________________________________ PHONE: (   )____________________RELATIONSHIP:________________________

☐ I GIVE PERMISSION FOR THE STAFF AT THE NORTHERN UTAH EYE CENTER TO:

1. SEND APPOINTMENT REMINDERS TO MY PHONE NUMBERS LISTED ON THE REGISTRATION FORM.
2. TO CALL ME AT HOME, WORK OR ON MY CELL PHONE TO SET UP APPOINTMENTS FOR ROUTINE EYE EXAMS OR PROCEDURES.
3. TO CALL ME AT HOME, WORK OR ON MY CELL PHONE TO REMIND ME OF MY APPOINTMENTS.

☐ I **DO NOT** GIVE PERMISSION FOR THE NORTHERN UTAH EYE CENTER STAFF TO DO THE ABOVE MENTIONED.

CONSENT FOR TREATMENT

I AUTHORIZE AND CONSENT TO THE TREATMENT(S) TO BE RENDERED BY THE NORTHERN UTAH EYE CENTER PHYSICIANS AND STAFF AS DEEMED NECESSARY. I ALSO AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIMS AND TO OBTAIN ANY MONEY THAT MAY BE OWED.
I HAVE READ AND AGREE WITH THE ABOVE POLICIES.

X____ DATE:________________________

Signature of Patient or Responsible Party

Patient Registration

(Please Print)

Where did you hear about us? ☐ Friend ☐ Physician ☐ Internet ☐ Phone Book ☐ Other ___________________

Referring Physician:____ Phone:______________________

List any family members seen in our clinic:____

Patient Information

Patient's Name:___________________________________ Email:______________________________

Last First Middle

Preferred Name:______________________ Marital Status (circle one): Single Married Divorced Widow/Widower

Mailing Address:____

Street Apt. City State Zip

Home Address:____

Street Apt. City State Zip

Home Phone: ( )____________ Work Phone: ( )_______________ Cell Phone: ( )________________

Date of Birth (mm/dd/yyyy):______/______/_______ Age: ______ Social Security #:______-____-_____ Sex: M or F

Employer or School:____ If Student (circle one): Full-time or Part-time

Nearest Friend or Relative Not Living With Patient - Name:___________________________ Phone:____________________

Responsible Party Information

Responsible Party:_______________________________________ Relationship to Patient:_________________________

Mailing Address:____

Street Apt. City State Zip

Home Address:____

Street Apt. City State Zip

Home Phone: ( )_______________ Work Phone: ( )_______________ Cell Phone: ( )_______________

Date of Birth (mm/dd/yyyy):______/______/_______ Social Security #:______-____-_____ Sex: M or F

Email:____ Employer:________________________________

Spouse:__________________ Date of Birth (mm/dd/yyyy):______/_____/______ Social Security #:_____-______-______

Work Phone: ( )_____________ Cell Phone: ( )_____________ Spouse Employer:_______________________

Insurance Information

Insurance - Primary:____ ID#:______________________________

Name of Insured:____ Date of Birth (mm/dd/yyyy):_____/_____/______

Relationship to Patient:_______________________________________

Insurance - Secondary:____ ID#:______________________________

Name of Insured:____ Date of Birth (mm/dd/yyyy):_____/_____/______

Relationship to Patient:_______________________________________

PLEASE ALSO COMPLETE THE REVERSE SIDE OF THIS FORM