Utah Eye Associates
State-of-the-art medical and general eyecare

150 South 1000 East, Suite 100
Salt Lake City, UT 84102
Phone: 801-363-2851
Fax: 801-363-7186
Website: www.UtahEyeAssociates.com

Date: _____

PATIENT HISTORY QUESTIONAIRE

Last Name_____ First Name _____ MI _____
Address_____ City _____ State _____ Zip _____
Work Phone _____ Home Phone _____ Cell Phone _____
Date of Birth _____ Occupation_____ Employer_____
Sex ❑M ❑F Marital Status _____ Referred by _____
Emergency Contact _____ Ethnicity _____ Email _____

Medical Information

Do you have problems in the following areas? (Please check yes or no)

Gastrointestinal	❑ Yes	❑ No	Nervous	❑ Yes	❑ No	Endocrine (glands)	❑ Yes	❑ No
Ears/Nose/Throat	❑ Yes	❑ No	Urinary	❑ Yes	❑ No	Blood/Lymph	❑ Yes	❑ No
Cardiovascular	❑ Yes	❑ No	Muscles/Bones	❑ Yes	❑ No	Allergic/Immunologic	❑ Yes	❑ No
Respiratory	❑ Yes	❑ No	Skin	❑ Yes	❑ No	Headaches	❑ Yes	❑ No
High Blood Pressure	❑ Yes	❑ No	Eyes	❑ Yes	❑ No	Mental	❑ Yes	❑ No

Please explain _____
Diabetes ❑ Yes ❑ No Type_____ Years diagnosed _____ HbA1c _____ Controlled _____
Current medications _____

_____
Medications allergy or seasonal _____
Name and Address of Family doctor_____ Phone number _____
Surgeries _____

Family History

High blood pressure	❑ Yes	❑ No	Relation _____	Macular Degeneration	❑ Yes	❑ No	Relation _____	
Diabetes	❑ Yes	❑ No	Relation _____	Retinal Degeneration	❑ Yes	❑ No	Relation _____	
Glaucoma	❑ Yes	❑ No	Relation _____	Cataracts	❑ Yes	❑ No	Relation _____	
Alzheimer's	❑ Yes	❑ No	Relation _____	Parkinson's	❑ Yes	❑ No	Relation _____	

Personal Eye Information

Describe your eye problem _____
Have you had any eye surgery ❑ Yes ❑ No Describe _____
Have you had any eye injury ❑ Yes ❑ No Describe _____

Do you have any of the following?

Glaucoma	❑ Yes	❑ No	Cataracts	❑ Yes	❑ No	Dry Eyes	❑ Yes	❑ No
Macular degeneration	❑ Yes	❑ No	Retinal degeneration	❑ Yes	❑ No	Flashes/Floaters	❑ Yes	❑ No
Sandy, gritty feeling	❑ Yes	❑ No	Watery/itchiness	❑ Yes	❑ No	Blurred vision	❑ Yes	❑ No
Have you had LASIK	❑ Yes	❑ No	Do you wear glasses	❑ Yes	❑ No	Contact lenses	❑ Yes	❑ No

Smoke or Drink: ___ _____

Doctor Use Only

Reviewed by _____ Any changes ❑ Yes ❑ No Date _____
Reviewed by _____ Any changes ❑ Yes ❑ No Date _____
Reviewed by _____ Any changes ❑ Yes ❑ No Date _____

cHIE Patient Consent & Change Form

THE CLINICAL HEALTH INFORMATION EXCHANGE (cHIE) IS HERE TO MAKE YOUR LIFE SIMPLER AND SAFER. With this form, you are choosing whether to allow your medical information to be accessed through a statewide secure electronic system called the cHIE.

FILL OUT THIS FORM COMPLETELY AND RETURN IT TO YOUR PARTICIPATING CHIE HEALTHCARE PROFESSIONAL.

PATIENT INFORMATION (PLEASE PRINT):

FIRST NAME:

MIDDLE NAME:

LAST NAME:

DATE OF BIRTH: MM-DD-YYYY

ADDRESS:

CITY:

STATE:

ZIP:

GENDER:

☐ MALE ☐ FEMALE

CONSENT OPTIONS PLEASE CHOOSE ONLY ONE BOX BELOW:

☐ PARTICIPATE: I give consent to share and allow access to my medical records to participating healthcare professionals through the cHIE.

☐ LIMITED: I give consent to share and allow access to my medical records to participating healthcare professionals through the cHIE for this non-emergency medical visit or for any emergency anytime. A new consent form must be completed for each non-emergency medical visit.

☐ NOT-PARTICIPATE: I do not want my medical records accessed by any healthcare professional through the cHIE, even in an emergency. .

You can change your consent at any time by going to a participating cHIE healthcare professional and requesting a change. Changes made to consent will be processed in a reasonable amount of time, and may not be immediate. Your current consent status will remain in effect until your request can be updated.

By signing this form, I acknowledge that I have read and understand my consent options as described herein. I also understand I can change my consent at any time by completing a new cHIE Patient Consent Form and returning it to a participating cHIE healthcare professional.

SIGNATURE OF PATIENT OR PATIENT'S LEGAL REPRESENTATIVE

DATE OF THIS CONSENT DECISION

PRINT NAME OF LEGAL REPRESENTATIVE (IF APPLICABLE)

RELATIONSHIP OF LEGAL REPRESENTATIVE

By signing as the patient's legal representative I certify that: the Patient's Name is accurate and correct. that I am the Parent or Legal Guardian of the Patient, and that I have authority to sign this Consent on the Patient's behalf.

REQUIRED - CONSENT WITNESSED BY AUTHORIZED AGENT To protect your privacy and verify your identity, your signature on this consent form must be witnessed by your healthcare professional or a cHIE representative.

Name of Organization: _____ Name of Witness: _____

As a witness to this Consent, I attest that the above signer is personally known to me or has established his/her identity with me by satisfactory photo ID, insurance card, or other evidence of identity customarily relied upon in healthcare.

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Patient's Insurance Responsibility

I, _____, understand that Utah Eye Associates will bill

(a) First my medical insurance for the services provided, then

(b) Secondly my vision insurance, if they are participating providers.

Unless specifically stated, at the time of service, Utah Eye Associates will not bill any insurance for glass or contact lenses. I also understand that if I do not provide all current insurance information, at the time of service, I will be responsible for all charges. I will provide the following:

Name of Primary Insured: _____

Date of Birth: _____

Address of Insured: _____

Relationship of Insured: _____

Utah Eye Associates is not responsible to file any insurance, if such information is provided, after the date the services are rendered. Utah Eye Associates may charge a filing fee, to the patient, at any time to file any insurance. I understand that it is not the responsibility of the above office to negotiate payment and/or coverage for any services rendered.

I understand that filing for insurance coverage, except for Medicare and Medicaid, is a service of Utah Eye Associates. I agree to pay all outstanding balances that are 60 days past due and all collection fees, if necessary, which can be up to 40% of the balance due.

The undersign fully understands the above and the patient/guardian accepts the responsibility for all charges assessed.

_____ _____

Utah Eye Associates Patient/ Guardian

_____ _____

Date Date

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name_____

Address_____

Telephone_____ E-Mail_____

SS number_____ Primary Ins./No_____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare procedures.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities and healthcare procedures, of the uses and disclosures we may make of your protected healthcare information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices at any time by contacting the doctor at 150 South 1000 East, SLC, UT 84102 or call 801.363.2851.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the above office. Please understand that revocation of this Consent will not affect any action we took before we receive your revocation and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare Procedures.

SIGNATURE_____ DATE _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following

Representative's name_____ Relationship _____

A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If your insurance doesn't pay for **D.** Services below, you may have to pay. Insurance does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect they may not pay for the **D. Services** below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
○ Refraction ○ Topography	Non-Covered Charges Non-Covered Charges	35.00 70.00

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** Services listed above.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D. Services** listed above. You may ask to be paid now, but I also want my insurance billed for an official decision on payment, which is sent to me on a Explanation of benefits(EOB). I understand that if my insurance doesn't pay, I am responsible for payment, but **I can appeal to my insurance** by following the directions on the EOB. If my insurance does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D. Services** listed above, but do not bill my insurance. You may ask to be paid now as I am responsible for payment. **I cannot appeal if my insurance is not billed**.

☐ **OPTION 3.** I don't want the **D. Services** listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if my insurance would pay.**

H. Additional Information:

This notice gives our opinion, not an official Insurance decision.

Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date: