Michael West, O.D
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Eye Care SOLUTIONS

See Well...Live Well

9565 S 700 E
Sandy, UT 84070
(801)572-3937

Patient Information

Date____________________

Patient ____________________ ______________________ ______
Last First MI

Address____

________ ______________________ _______ _________________
Apt# City State Zip

Sex: M F Birth date_______/______/_________ Age__________

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient SS #____

Home Phone ____

Cell Phone____

Email ____

Occupation ____

Employer____

Employer Address____

Spouse's Name____

Birthdate ____________________ SS #_______________________

Occupation ____

Spouse's Employer ____

Who may be thank for referring you? ________________________

In case of Emergency, Contact ____________________________
Name

Relationship To Patient____________________________________

_________________ ___________________ ________________
Home phone Cell Phone Work Phone

Referred By ____

Insurance

Who is responsible for this account? _______________________

Relationship to Patient_________________________________

Vision Plan (circle)

VSP EYEMED DAVIS VBA Superior Avesis None

Other______________________

Subscribers Name ______________________________________

Member ID # ____

Employer ____

Birth date ____/_____/______ SS#_________________________

Medical Insurance (ALTIUS, BLUE CROSS, MEDICARE ETC)

Name of Insurance______________________________________

Member ID # ____

Subscribers Name ______________________________________

Employer ____

Birth date ____/_____/______ SS#_________________________

Relationship to Patient__________________________________

_Medical Insurance (ALTIUS, BLUE CROSS, MEDICARE ETC)

Name of Insurance______________________________________

Member ID # ____

Subscribers Name ______________________________________

Employer ____

Birth date ____/_____/______ SS#_________________________

Relationship to Patient__________________________________

Financial Terms

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I authorize Eye Care Solutions to release any part of my medical record required to process an application for payment for services rendered or medical supplies delivered to my health insurance company or other third party payer.

AUTHORIZATION TO ASSIGN BENEFITS

I authorize and assign benefits from my Health insurance company or third party payer to be paid directly to Eye Care Solutions.

GUARANTOR RESPONSIBILTY AND 3rd PARTY LIABILITY

I Accept responsibility for payment of all charges resulting from my medical evaluation and treatment. This includes charges for medical evaluation, any medical procedure performed, medical supplies given or administered. Where the payment allowed by my health insurance for any service is less than the charge for that service. I agree to pay the balance of the full charge. I understand that payment is due at the time of service. I agree to pay any co-payment or deductible amount required by my health insurance policy at the time of service. I understand that an insurance claim form will be submitted to my primary health insurance company by the staff of Eye Care Solutions.

I agree to pay a monthly finance charge of 1.5% (18% annual Interest rate) or $2.00, whichever is greater on any balance on my account that is outstanding for over 90 days. I agree to pay a $30 penalty fee for any check that I write that is returned for insufficient funds. I agree to make payment in full for services performed within 90 days. I agree to make payment in full for services performed within 90 days of the date of service. I understand that failure to make payment within this time may result in the referral of my account to a collection agency. In the event that collection or legal action is taken by Eye Care Solutions to obtain payment for up to 40% of the total bill, with or without suit, attorney's fees, court costs and other expenses that result from such action.

I accept responsibility for obtaining any written referral, or prior approval, or authorizations for service required by my health insurance company or other third party payer. I agree to pay the full costs of any service which is either disallowed by health insurance company or which is not paid because such prior authorization was not obtained.

I certify that I have read this agreement and by my signature, I agree to the terms set forth above.

Patient/Guarantor Signature ____ **Date**______________________________
(must be 18 years old)

Print Guarantors name___________________________ **Relationship to Patient**________________________________

Medical History

Eye Health History

Previous Eye Dr.___________________________

Date of Last Exam _________________________

Do you wear Glasses? YES No

All the time Occasionally Reading Driving TV

Do you wear Contacts? YES NO

Type__________________________________

hours/day______________________________

Describe any problems you have with your contacts _______________________________

____

Condition					Condition				
Bloodshot eyes	☐	Yes	☐	No	Headaches	☐	Yes	☐	No
Blurred Vision- Near/Far	☐	Yes	☐	No	Itching Eyes	☐	Yes	☐	No
Burning Eyes	☐	Yes	☐	No	Light Sensitive	☐	Yes	☐	No
Cataracts	☐	Yes	☐	No	Loss of Vision	☐	Yes	☐	No
Crossed Eyes	☐	Yes	☐	No	Migraine Headaches	☐	Yes	☐	No
Discharge from Eyes	☐	Yes	☐	No	Night Vision, Poor	☐	Yes	☐	No
Dizzy Spells	☐	Yes	☐	No	Red Eyes	☐	Yes	☐	No
Double Vision	☐	Yes	☐	No	Seeing Halos	☐	Yes	☐	No
Dry Eyes	☐	Yes	☐	No	Seeing Flashes	☐	Yes	☐	No
Eye Injury	☐	Yes	☐	No	Temporary Loss of Vision	☐	Yes	☐	No
Eye Strain	☐	Yes	☐	No	Vision Poor	☐	Yes	☐	No
Fainting spells, Blackouts	☐	Yes	☐	No	Twitching Eyelid	☐	Yes	☐	No

Health History

	Yourself		Family Members			Yourself		Family Member	
AID/HIV	☐ Yes	☐ No	☐ Yes	☐ No	Hepatitis (type ____)	☐ Yes	☐ No	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	☐ Yes	☐ No
Artifical Heart Valve	☐ Yes	☐ No	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	☐ Yes	☐ No
Artifical joints	☐ Yes	☐ No	☐ Yes	☐ No	Lazy Eye	☐ Yes	☐ No	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	☐ Yes	☐ No	Lupus	☐ Yes	☐ No	☐ Yes	☐ No
Bleeding	☐ Yes	☐ No	☐ Yes	☐ No	Migraine Headaches	☐ Yes	☐ No	☐ Yes	☐ No
Blindness	☐ Yes	☐ No	☐ Yes	☐ No	Pace Maker	☐ Yes	☐ No	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	☐ Yes	☐ No	Poor Color Vision	☐ Yes	☐ No	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No	☐ Yes	☐ No	Retinal Disease	☐ Yes	☐ No	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	☐ Yes	☐ No	Shingles	☐ Yes	☐ No	☐ Yes	☐ No
Drug Sensitivity	☐ Yes	☐ No	☐ Yes	☐ No	Skin Conditions	☐ Yes	☐ No	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	☐ Yes	☐ No	Stroke	☐ Yes	☐ No	☐ Yes	☐ No
Epilepsay	☐ Yes	☐ No	☐ Yes	☐ No	Thyroid Conditions	☐ Yes	☐ No	☐ Yes	☐ No
Eye Surgery	☐ Yes	☐ No	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No	☐ Yes	☐ No
Glaucome	☐ Yes	☐ No	☐ Yes	☐ No	Turned Eye	☐ Yes	☐ No	☐ Yes	☐ No
Hay Fever	☐ Yes	☐ No	☐ Yes	☐ No	Other____________	☐ Yes	☐ No	☐ Yes	☐ No
Heart Condition	☐ Yes	☐ No	☐ Yes	☐ No	Are you Pregnant	☐ Yes	☐ No		
Macular Degeneration	☐ Yes	☐ No	☐ Yes	☐ No	Tobacco Use	☐ Yes	☐ No		
Mental Illness	☐ Yes	☐ No	☐ Yes	☐	Alcohol Use	☐ Yes	☐ No		

Medications

List Medications you are currently taking, Including Eye Drops:

____

____

____

Allergies

List your allergies to medications or other substances

____

____

____

Contact Wearers Agreement:

Evaluation Fee is between $40-$60.

1. The fee depends on time requirement and complexity of the contact exam, Keratoconus and specialty fit may require an additional Fee. (Routine eye exams do not include contact lens evaluations and most insurance do not cover this.)
2. The contacts that the Dr. prescribes will be your contact prescription. If you need to have the prescription changed, due to comfort or vision a follow up must be scheduled within two weeks of the exam date. (If you cannot make it back in within the two week limit let us know we will work with you.)
3. This fee covers training (for new wearers), follow up visits, and any changes in contact lens brands/prescription.
4. ***Contact evaluations are required every year to renew or update contact lens prescriptions***. Contact lenses are a medical devise and cannot be dispensed without a current prescription, which is good for one year**.**
5. This exam is to safeguard your eye health and insure there is no irritation or compromised health, as contact wearers are at a greater risk for infection and other sight threatening conditions. At first sign of irritation contacts should be removed until irritation is resolved, which we recommend having a backup pair or glasses to be used.

Contact Lens Orders

1. We keep our prices competitive and offer mail in rebates for 6 month and yearly supplies on most brands
2. We require payment for contacts by the time of pickup. All direct mail orders need to be paid for when ordered.
3. ***Do not*** *open any box of contacts unless satisfied with prescription, We do accept returned unopened boxes as long as they are not damaged or written on. Hard and Gas perm lenses can be returned within one month for replacement or partial credit. We only accept products we have dispensed; we are not responsible for lenses dispensed elsewhere.*

I have read and understand this agreement,

Signature____ Date___________________

Acknowledgment of Privacy Notice

By signing this acknowledgment of Notice of Privacy Practices, I acknowledge that I have read and understood the Notice of Privacy Practices of Eye Care Solutions and have the right to receive a copy for review and to keep for my records on the date identified below.

I understand that Eye Care Solutions may use and disclose necessary personal health information (for example, my name, address, insurance subscriber identification numbers, eye exam information and/or type of products provided) to another party to permit Eye Care Solutions to perform administrative duties, provide me with eye care services, and products, process my insurance claims, and communicate with me regarding vision care services provided by our office. This could also include mailings and/or phone calls of exam reminders or information about services and/or products provided by Eye Care Solutions.

I can be assured that Eye Care Solutions does not sell my personal health information of any kind to a third party for such party's own use. I authorize Eye Care Solutions to submit my vision benefit claims to my plan sponsor or health plan, to receive reimbursement for the vision services and products that I have received.

____ ______________

Signature of Patient or Patient's Legal Representative (must be 18 or older) Date

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Effective Date of Notice: July 28, 2014