

**Cataract & Lasik Center of Utah**  
**Patient Information**

Patient Name \_\_\_\_\_ Age \_\_\_\_\_ Birth Date \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone (\_\_\_\_) \_\_\_\_\_ Cell/Other Phone (\_\_\_\_) \_\_\_\_\_ Social Security# \_\_\_\_\_  
M \_\_\_ F \_\_\_ Single \_\_\_ Married \_\_\_ Divorced \_\_\_ Widowed \_\_\_ Employed \_\_\_ Student \_\_\_ Retired \_\_\_  
Your Employer \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_  
Name of Spouse \_\_\_\_\_ Social Security # \_\_\_\_\_ Birth Date \_\_\_\_\_  
Names/Phone #'s of Parents (if a minor) \_\_\_\_\_  
Name & Phone # of nearest relative not living with you \_\_\_\_\_  
Emergency Contact Name/Phone: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

**Insurance Information**

**Primary Insurance** \_\_\_\_\_  
ID# \_\_\_\_\_ Group# \_\_\_\_\_  
Insured's name \_\_\_\_\_  
Insured's birth date if not patient \_\_\_\_\_  
Insured's relationship to patient \_\_\_\_\_

**Secondary Insurance** \_\_\_\_\_  
ID# \_\_\_\_\_ Group# \_\_\_\_\_  
Insured's name \_\_\_\_\_  
Insured's birth date if not patient \_\_\_\_\_  
Insured's relationship to patient \_\_\_\_\_

**How did you hear about us:**

Website: \_\_\_\_\_  
Radio Station: <sup>(name)</sup> \_\_\_\_\_  
Friend: <sup>(name)</sup> \_\_\_\_\_  
Newspaper: <sup>(name)</sup> \_\_\_\_\_  
Optometrist: <sup>(name)</sup> \_\_\_\_\_  
Senior Center <sup>(name)</sup> \_\_\_\_\_

Mailer/Postcard: <sup>(please List)</sup> \_\_\_\_\_  
Yellow Pages: \_\_\_\_\_  
Family: <sup>(name)</sup> \_\_\_\_\_  
Expo: <sup>(name)</sup> \_\_\_\_\_  
Other: \_\_\_\_\_

**Agreement & Permission to Release Information**

I hereby assign and instruct my insurance carrier to pay all medical care benefits to the Cataract & Lasik Center of Utah and/or Jamie M. Monroe, M.D. I hereby authorize the Cataract & Lasik Center of Utah and/or Jamie M. Monroe, M.D. to furnish any or all information requested by all companies under whose policies I am insured. For service rendered to the above patient, I, the undersigned, am fully responsible for payment and guarantee payment in full at time of service. It is my responsibility to negotiate with my insurance company regarding claims. If I have Medicare, I realize I am fully responsible for payment of my deductible and 20% of the allowable. In the event that payment in full for charges incurred is not made, I agree to pay all costs of collection including a 50% collection fee, attorney fees, court costs and interest at the rate of 1.5% per month (18% per year).

**Your exam today may include a refraction. This is the procedure used to determine the prescription for your eyeglasses. However, this service is not covered by Medicare. In some cases, other insurance carriers may pay all or part of this procedure. In the event your insurance will not pay, the portion of the fee you will be responsible to pay is \$ 30.**

**I understand that, as part of the preparation for my LASIK surgery, it will be necessary that I undergo a dilated eye examination. Should I decide not to proceed with LASIK by my choice or because the dilated examination demonstrates I am not a LASIK candidate, I will be responsible for the examination fee. Should I proceed with surgery, the fee will be included in the cost of LASIK.**

Signed \_\_\_\_\_ Witness \_\_\_\_\_ Date \_\_\_\_\_

**(over please)**

## PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will the cease
- The Practice may condition treatment upon the execution of this Consent

Signature: \_\_\_\_\_

This Consent was signed by: \_\_\_\_\_  
Printed Name –Patient or Representative

Relationship to Patient (if other than patient): \_\_\_\_\_

Date: \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_

In front of: \_\_\_\_\_  
Printed name – Practice representative