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___
E-Mail Address: ______________________________________

Ethnicity: Are you Hispanic or Latino? ☐ Yes ☐ No Language: ____________________________________

Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐White ☐ Other

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 #:____________________________

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: (name) ___________________________
Friend: (name) _______________________________
Newspaper: (name)______________________________
Optometrist: (name) ____________________________
Senior Center (name) ___________________________

Mailer/Postcard:(please List) ______________________
Yellow Pages:_________________________________
Family: (name) ___________________________________
Expo: (name) _____________________________________
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 33% collection fee, attorney fees, court costs and interest at the rate of 1.5% per month (18% per year) as allowed by Utah Code Annotated, sec. 12-1-11.

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)

SUMMARY OF PRIVACY PRACTICES PATIENT CONSENT FORM

This summary of our privacy practices contains a condensed version of our Notice of Privacy Practices. Our full-length Notice is available upon request. Date of Last Revision: 9-23-2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand that your medical information is personal to you, and we are committed to protecting the information about you. As our patient, we create medical records about your health, our care for you, and the services and/or items we provide to you as our patient. By law, we are required to make sure that your Protected Health Information is kept private.

How will we use or disclose your information?

- For medical treatment
- To obtain payment for our services
- In emergency situations
- For appointment and patient recall reminders
- To run our Practice more efficiently and ensure all our patients receive quality care
- For research
- To avert a serious threat to health or safety
- For organ and tissue donation
- For workers' compensation programs
- In response to certain requests arising out of lawsuits or other disputes

If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact our office manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Signature: ____ Date: _______/_____/_______

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

Relationship to Patient (if other than patient): _______________________________________

Witnessed by: ________________________________
Printed name – Practice Representative

We are providing information to help you make an informed decision about your health care. You have the right to obtain healthcare services and products from the Cataract and Lasik Center of Utah as well as any other health care provider you choose. Our doctors and staff completely respect your decision and will not treat you any differently if you choose to use or purchase a product or service other than those that we recommend. Upon request, we can provide information about alternative products or services.

By initialing below you acknowledge and accept the information above.

Patient Initials: _____________

During the course of your visit at the Cataract and Lasik Center of Utah, there may be discussions, referrals, prescriptions or otherwise recommended products or services distributed, provided or endorsed by ALPHAEON Corporation. Jamie Monroe has ownership interest in Strathspey Crown Holdings, LLC, the parent company of ALPHAEON.