Welcome to the
Eye Clinic & Contact Lens Center
Dr. Todd J. Lewis
Thank you for letting us take care of your eyecare needs.

Today's Date:_____

PATIENT NAME:
Name:_____Birthdate: _____ SS# _____
Age:_____ Sex: M /F Home Phone:_____Cell Phone:_____
Address: _____City:_____State:_____Zip:_____
Employer_____ Employer Phone #:_____
Marital Status: Single Married Divorced Separated Widow
Email:_____

EMERGENCY CONTACT: (Nearest relative not living with you)
Name:_____Phone:(_____)_____-_____

Who may we thank for referring you to our office?_____

SPOUSE OR PARENT INFORMATION:
Name:_____Date of Birth: _____ Relationship to patient:_____
Is this person currently a patient in our office? YES NO
Address:_____ City:_____ State:_____ Zip:_____
Contact Phone #:_____ SS#:_____
Employer Name:_____Employer Phone:_____
Email:_____

INSURANCE INFORMATION:

PRIMARY INSURANCE	**SECONDARY INSURANCE**
Name of Insured:_____	Name of Insured:_____
Birth Date:_____	Birth Date:_____
Address:_____	Address:_____
If not the same as patient.	If not the same as patient.
Subscriber ID:_____	Subscriber ID:_____
Group #:_____	Group #:_____
Insurance Company:_____	Insurance Company:_____
Insurance Phone #:_____	Insurance Phone #:_____
Employer Name:_____	Employer Name:_____
Relationship to patient:_____	Relationship to patient:_____

I authorize Dr. Todd J. Lewis or his disignees to release financially identifiable information and treatment descriptions and information, either electronically, by facsimile, or paper form to my insurance carrier or any related entities that require such information to be submitted.

I certify that the above information is correct.

Signature: (Parent/Guardian if patient is a minor)_____ Date:_____

Revised 10-2014

Eye Clinic and Contact Lens Center of Utah Valley, P.C. and CottonTree Optical
(Eye Clinic)
FINANCIAL POLICIES

Thank you for choosing Dr. Todd J. Lewis for your eyecare provider. We are committed to providing you with quality treatment and a posative experience. Please understand that **PAYMENT IS DUE AT TIME OF SERVICE**. Our office accepts cash, check, and debit/credit cards.

INSURED PATIENTS

- It is your responsibility to read and understand the contract and benefits that are abailable to you by your insurance company.
- As a service to you we will file insurance claims for services we provide , but it is your responsibility to make sure your insurance company has paid these claims.
- **INSURANCE CARD:** If you do not have your insurance card or proof of insurance, YOU are expected to pay in-full for your visit at the time of services.
- **CO-PAYMENTS:** You are required to make this payment at the time of service.
- **DEDUCTIBLES:** Payment of all deductibles are due at the time of services.
- **REFERRAL FORMS:** Many insurance companies require patients to bring a referral form from their Primary Care Physician at the time of our service. Any charges not paid by your insurance company because we had no referral to submit, will be **YOUR** responsibility. Always keep a copy of all referral forms.
- **PRE-AUTHORIZATION:** Many insurance companies are requiring pre-authorization for special procedures. On your request, we will pre-authorize special procedure with your insurance company. You must call them to confirm your benefits as they do not tell us what benefits are available when we pre-authorize. **PRE-AUTHORIZATION IS NOT A GUARANTEE OF BENEFITS.**

FEES AND COLLECTIONS

Our office requires a 24 hour notice on cancelation of appointments. If you do not provied 24 hours you will be charged a $25.00 fee.

I agree to pay all amount(s) owed within 30 days of when such amount(s) are incurred. I understand that it is my responsibility to provide my correct/updated insurance information and that this office will bill my insurance as a courtesy to me. However, regardless of insurance coverage, I agree that it is and shall remain my responsibility to pay all amounts owing as set forth herein. I agree that interest will accrue on all past-due amounts at the rate of 18% per annum (1.5% per month) until paid in full. In the event any amount(s) is/are referred to a third party debt collection agency, I agree that in addition to any other amount(s) allowed for by law, (such as interest, court costs, reasonable attorney's fees, etc.) I will also be responsible for a collection fee of up to 50% of the principal amount(s) owing as allowed by Utah Code Annotated, sec. 12-1-11. The terms of this paragraph shall apply to all amount(s) incurred by me or by any individual for whom I have legal responsibility whether such amount(s) are incurred today or after today.

ASSIGNMENT OF BENEFITS AND FINANCE CHARGES: I understand and accept FULL financial responsibility for services / products provided to me and/or my dependants by the Eye Clinic and Contact Lens Center of Utah Valley, P.C. and CottonTree Optical (Eye Clinic).

I hereby assign my insurance benefits to be paid directly to the Eye Clinic. Payment of all deductibles are due at the time of services. I understand that I am financially responsible for all non-insurance-covered services/products provided by the Eye Clinic. I also know that it is my responsibility to know and understand my insurance benefits and it is not the responsibility of the Eye Clinic to interpret those benefits or to collect them.

Signature:(parent/guardian if a minor)_____**Date:**_____

I acknowledge that I was given the opportunity to read a copy of the HIPPA Privacy Policies. I agree to disclose to the doctor names of any individual with whom I authorize the doctor to discuss my eyecare.

Signature: (parent/guardian if a minor)_____**Date:**_____

Name: _____ Birth Date: ___/___/_____ Today's Date: ___/___/_____

Past Medical History

List your current medications: ☐ None_____

_____

Are you allergic to any medication? ☐ No ☐ Yes **(List):**_____

List major illness, injury, or surgery: _____

List eye illness, injury, or surgery: _____

Date of last eye examination: ___/___/_____ Doctor/Clinic: _____

Do you wear glasses? ☐ No ☐ Yes Age of your current lenses? _____

Do you wear contacts? ☐ No ☐ Yes Age of your current lenses? _____ Type of contacts: _____

Have you had LASIK? ☐ No ☐ Yes Are you interested in LASIK? ☐ No ☐ Yes

Review of Systems (Do you currently have, or have you ever had, any problems in the following areas?)

EYES

Blurred Vision ☐ No ☐ Yes _____
Loss of Vision ☐ No ☐ Yes _____
Double Vision ☐ No ☐ Yes _____
Floaters ☐ No ☐ Yes _____
Flashes ☐ No ☐ Yes _____
Dry Eyes ☐ No ☐ Yes _____
Redness ☐ No ☐ Yes _____
Excess Tearing ☐ No ☐ Yes _____

CONSTITUTION

Weight Loss/Gain ☐ No ☐ Yes _____

SKIN DISEASE ☐ No ☐ Yes _____

NEUROLOGIC

Headaches ☐ No ☐ Yes _____
Seizures ☐ No ☐ Yes _____

ENDOCRINE

Thyroid ☐ No ☐ Yes _____
Diabetes ☐ No ☐ Yes _____

EARS/NOSE

Sinus Infection ☐ No ☐ Yes _____

RESPIRATORY

Asthma ☐ No ☐ Yes _____
Emphysema ☐ No ☐ Yes _____

VASCULAR

High Blood Pressure ☐ No ☐ Yes _____
Heart Disease ☐ No ☐ Yes _____

GASTRIC

Intestinal Disease ☐ No ☐ Yes _____

GENITOURINARY

Bladder Infection ☐ No ☐ Yes _____
Kidney Disease ☐ No ☐ Yes _____

BONES/JOINTS

Rheumatoid Arthritis ☐ No ☐ Yes _____

LYMPHATIC

Swollen Gland/Node ☐ No ☐ Yes _____

IMMUNOLOGIC

Lupus ☐ No ☐ Yes _____

PSYCHIATRIC

Depression ☐ No ☐ Yes _____

OTHER _____

Family History (Please note any family history for the following conditions & list their **relationship** to you)

Blindness ☐ No ☐ Yes _____
Cataract ☐ No ☐ Yes _____
Glaucoma ☐ No ☐ Yes _____
Macular Degen. ☐ No ☐ Yes _____
Retinal Detach. ☐ No ☐ Yes _____
Crossed/Lazy Eye ☐ No ☐ Yes _____
Keratoconus ☐ No ☐ Yes _____

Diabetes ☐ No ☐ Yes _____
High Blood Pressure ☐ No ☐ Yes _____
Cancer ☐ No ☐ Yes _____
Kidney Disease ☐ No ☐ Yes _____
Thyroid Disease ☐ No ☐ Yes _____
Arthritis ☐ No ☐ Yes _____
Heart Disease ☐ No ☐ Yes _____

Social History (This information is kept strictly confidential)

Are you: ☐ Married ☐ Divorced ☐ Widowed ☐ Single

Have you ever been exposed or infected with:

☐ HIV ☐ Syphilis ☐ Hepatitis ☐ Gonorrhea ☐ None

Do you use tobacco? ☐ No ☐ Yes

Do you drink alcohol? ☐ No ☐ Yes

Do you use illegal drugs? ☐ No ☐ Yes

Doctor's Signature: _____ Date: _____

FOR OFFICE USE ONLY (Change in Medical History) _____

_____

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