PATIENT INFORMATION

Patient's Name: Last ____________________ First __________________ Middle________________
Preferred/ Nickname :__________________________________
Gender: Male /Female **Ethnicity:** Hispanic/Latino □ Native Hawaiian/Other Island □ Not Hispanic/Latino □
Marital Status: Single □ Married □ Divorced □ Widowed □ Legally Separated □ Other □
Preferred method of contact: Postal □ Telephone □ Cell Phone □ Email □ Text □
Race: White □ Hispanic □ American Indian/Alaskan Native □ Asian □ Black or African American □ Native Hawaiian/Other Island □
Preferred Language: □ English □ Other_______________________
Address: ____**City:** ________________________ **State:** _________ **Zip:** ___________
Social Security# : ________- ______- ___________ **Birthdate:** _____ /______/________ **Age:** __________
Email Address: ____ **Texting is Okay:** yes/ no
Phones: Home______________________________ Cell______________________________ Work/School _____________________
Occupation: ____________________________ **Employer:** __________________________ **Employed:** Full time or Part time
Full time student □ **Part time student** □ **Name of School**___________________________ **Retired** □ **Military** □ **Not applicable** □

RESPONSIBLE PARTY INFORMATION

Responsible Party Name: Last_________________________________First_______________________________Middle______________
Address: _____________________________________ **City:** ________________________ **State:** _________ **Zip:** _________________
Social Security# : ________- ______- ___________ **Birthdate:** _____ /______/________ **Age:** __________
Email Address: ____ **Texting is Okay:** yes/ no **Nickname**:____________________
Phones: Home______________________________ Cell______________________________ Work/School _________________________
Occupation: ____________________________ **Employer:** __________________________ **Employed:** Full time or Part time
Full time student □ **Part time student** □ **Name of School**___________________________ **Retired** □ **Military** □ **Not applicable** □
Spouse's Last Name_____________________________ **First** ___________________________________**Middle**______________________
Relationship to Patient: ____ **Gender**: Male / Female

EMERGENCY CONTACT INFORMATION Please give the name of a relative or close friend not living with you:
Name: ____ **Relationship:** ______________________ Phone ____________________________
Address:____ City, State, Zip____

INSURANCE INFORMATION: You may fill in completely or just the Policy Holder Information and Insurance name and we will copy the card.

Primary Medical Insurance Company
Name of Policy Holder_________________________________
Relationship to Patient________________________________
Insured's Birthday____________________________________
Insurance Name______________________________________
Insurance Group #____________________________________
Insurance ID#____
Insurance Address_____________________________________

Secondary Medical Insurance Company
Name of Policy Holder__________________________________
Relationship to Patient_________________________________
Insured's Birthday_____________________________________
Insurance Name_______________________________________
Insurance Group #_____________________________________
Insurance ID#____
Insurance Address______________________________________

Primary Optical/ Vision Plan
Name of Policy Holder_________________________________
Relationship to Patient________________________________
Insured's Birthday____________________________________
Insurance Name______________________________________
Insurance Group #____________________________________
Insurance ID#____
Insurance Address_____________________________________

Secondary Optical/ Vision Plan
Name of Policy Holder__________________________________
Relationship to Patient_________________________________
Insured's Birthday_____________________________________
Insurance Name_______________________________________
Insurance Group #_____________________________________
Insurance ID#____
Insurance Address______________________________________

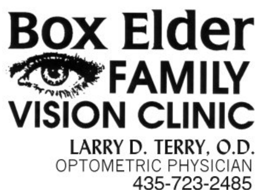
Payment for all services is the responsibility of the patient and is expected at the time of service.

Our office files primary and secondary insurance as a complimentary service to our patients. I/We agree that it is my responsibility to understand my insurance benefits and that I am ultimately responsible for all charges incurred. I/ We agree to pay all attorney fees, court costs, filing fees, including charges or commissions up to fifty percent that may be assessed by any collection agency retained to pursue this matter. I/ We further agree to pay interest at the rate of 1.5% per month (18% per year). There is a $22.00 service charge for all returned checks. There is a $15.00 late fee for all accounts over 60 days past due. For patient convenience, this office accepts most major credit cards.

I hereby authorize the release of medical information concerning my health condition and treatment by the doctors of this facility to my insurance company and the Health Care Financing Administration or its agents. I authorize payment of medical benefits be paid directly to provider or facility.

I understand that I am responsible to cancel appointments 24 hours in advance. I understand that if a 24-hour notice is not received at the clinic, I may be charged a $25.00 fee for missed appointments.

____________________________ ____
Date Signature of patient or legal guardian



BOX ELDER FAMILY VISION CLINIC

Notification and Acknowledgement of Notice of Privacy Practices Regarding Protected Health Information

Our *Notice of Privacy Practices* provides detailed information regarding how we may use and disclose protected health information about you. By law, we are required to gain your written acknowledgement of our *Notice of Privacy Practices,* of which you may request a copy. Our office strives to protect the privacy and the confidentiality of your medical, vision, and behavioral health information. The *Notice of Privacy Practices* describes many rights afforded to patients/ covered individuals regarding the handling of their personal health information. For a complete description of our practices, please refer to our *Notice of Privacy Practices.* You may receive a copy of the Notice from our office at:

Larry D.Terry, OD (Box Elder Family Vision Clinic)
Attention: HIPAA Privacy Officer
34 South Main Street
Brigham City, Utah 84302

We reserve the right to change the Notice, and if we do, you may obtain a copy of the revised Notice from the same location noted above.

Please acknowledge your receipt of this notification by signing below and returning it to the receptionist. Thank you.

____ _____________________________________
Signature of Patient or Personal Representative Date

____ _____________________________________
Name of Patient or Personal Representative Description of Personal Representative’s Authority

Designation for Release of Medical Information to a Family Member, Friend or Legal Representative

Introduction

It is the doctors' responsibility to ensure the doctor-patient relationship is confidential. The Health Information Portability and Accountability Act (HIPPA) allows physicians to use their professional judgement on disclosing certain personal health information to family, friends etc. without an authorization. This form is an aid to the physicians in making a determination on disclosing such information. Box Elder Family Vision Clinic realizes that there are times when you, the patient, may want another person to be knowledgeable about your medical information or medical needs. Your doctor wants you to be able, if you so desire, to name a person to whom you want the office staff/ doctors to speak with about your health information. To enable that, we would ask that you complete the form listed below.

Designation Statement

I, ____, designate the following person(s) to be able to speak to a doctor at Box Elder Family Vision Clinic, or other staff member, on my behalf. I hereby give permission to Box Elder Family Vision Clinic through its doctor and staff to release to my designee(s) any information about my medical condition or medical needs or the status of my account and I release Box Elder Family Vision Clinic its doctors and staff, from any claim of confidentiality in connection with the release of this information. I understand that I may revoke this release at any time by sending a written statement to our HIPAA Privacy Officer requesting such release.

Name(s) of designated Person(s): 1. ______________________________ 2. __________________________________
Relationship to patient: ______________________________ __________________________________
Phone Number: ______________________________ __________________________________

Patient: ___________________________ __________________ ____
Name Date of Birth Signature

Today's Date: ____________________________________