Welcome to Eyecare of Lehi
Eyecare for the Entire Family–Drs. Robert F. Gray & Collin R. Gray

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Patient information: **Today's Date: ____/____/____**

Patient Legal Name: _____ Preferred Name: _____
First Middle Last
Patient Birth Date: _____/_____/_____ Age: _____ Sex: M ___ F ___
Street Address: _____ City:_____ Zip: _____
Cell Number: (____) _____-_____ Secondary Number: (____) _____-_____ Text Reminders: Y / N
Secondary Number: (_____) _____-_____ Occupation: _____
Patient Social Security Number: _____ Email: _____
Please note in order to access your personal health record (including prescription access) we require a current & valid email address

Marital Status (Please circle one): Single Married Divorced Widowed Other
Race (Please circle one): White American Indian Pacific Islander Black/African American Alaskan Native Asian Other
Ethnicity (Please circle one): Hispanic or Latino Not Hispanic or Latino

Guardian if Under 18: _____ Guardian Phone Number: (_____) _____-_____
Preferred Pharmacy: _____ Pharmacy Phone Number: (_____) _____-_____
How did you hear about Eyecare of Lehi? _____

Primary Vision Insurance:
Insurance Company Name: _____ Member ID/SSN: _____
Responsible Member Name: _____ Date of Birth: _____/_____/_____
Employer: _____ Relationship to Patient: _____

Primary Medical Insurance:
Insurance Company Name: _____ Member ID/SSN: _____
Responsible Member Name: _____ Date of Birth: _____/_____/_____
Employer: _____ Relationship to Patient: _____

I understand that I need to provide 24 hours' notice to cancel my appointment or a $50 late fee will be assessed.
I understand that in order to access my personal health records a valid email is required
I understand that in order to be seen by a doctor a financial disclosure agreement must be signed
I understand that in order to receive a contact prescription my exam must include a contact fitting
I understand that ophthalmic lenses are a medical device & custom designed, therefore they cannot be refunded.

I hereby give my consent for Eyecare of Lehi to use and disclose my protected health information (PHI) to carry out treatments, payment and health care operations (TPO). I have the right to review the Notice of Privacy Practices (NPP) prior to signing this consent. Eyecare of Lehi reserves the right to revise its Notice of Privacy Practices at any time. A revised NPP may be obtained by forwarding a written request to Eyecare of Lehi. With this consent, Eyecare of Lehi may call my home, leave messages, send regular mail, or email in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls or communications pertaining to my clinical care, etc. By signing this form, I am consenting to allow Eyecare of Lehi to use and disclose my PHI to carry out TPO. I also agree to be responsible for any fees not covered by insurance and any collection charges, interest charges, legal fees and attorney fees on accounts past due.

_____
Signature of patient or legal guardian Printed Name Date

I authorize Eyecare of Lehi to use and disclose my health information to the following persons:

_____

Current Medical History

Do you wear glasses? **Y / N** If yes, how old is your present pair of lenses? _____
Do you wear contact lenses? **Y / N** If yes, how old is your current pair of lenses? _____
Which solution, if any, are you using? _____
If applicable, when was the last time you replaced your contact case? _____

Personal & Family Medical/Eye History

**Please indicate relation to family member on line provided*

Cancer:	Self / Family _____	Migraines:	Self/ Family _____
Diabetes Type 1:	Self / Family _____	Macular Degeneration:	Self/ Family _____
Diabetes Type 2:	Self / Family _____	Glaucoma:	Self/ Family _____
High Blood Pressure:	Self / Family _____	Amblyopia (lazy eye):	Self/ Family _____
Thyroid Problems:	Self / Family _____	Keratoconus:	Self/ Family _____

Others (Including eye surgeries, diseases, etc.):

_____
_____
_____

Are you currently taking any medications: **Y / N**
Medications & Dosage (including birth control, vitamins, OTC medications, herbs/natural treatments, and/or supplements)

_____
_____
_____

Do you have any allergies to medications? (if yes, explain):

_____
_____

Do you have any other allergies? (food, animals, latex, seasonal, etc.):

_____
_____

Social History

Do you drink alcohol? Y / N
Do you smoke? Y / N Current / Former / Never Do you vape? Y / N Current / Former / Never
Do you use a computer? Y / N if yes, how many hours per day: _____hours
How many hours per day are you using a cellular device (screen time)? _____ hours
Are you pregnant? Y / N Are you currently breastfeeding? Y / N
Height: _____ ft. _____ in. Weight: _____ lbs

Drs. Robert F. Gray & Collin R. Gray **Eyecare of Lehi**

Authorization and Financial Disclosure

In an effort to provide the best possible eye care for our patients, a mutual understanding of our payment policies is important. Our professional services are rendered to you, not the insurance company. Therefore, payment for services is **your responsibility**. We accept many forms of payment.

I understand:

- That my insurance policy is a contract between me and my insurance company, and that I must provide current insurance information so Eyecare of Lehi can accurately bill my insurance.
- That I authorize Eyecare of Lehi to release any information regarding my care to expedite claims or for record transfers, should that be requested.
- That I authorize Eyecare of Lehi to bill my medical insurance company for services provided, with payment to be made directly to Eyecare of Lehi or the doctor. Pre-paid vision plans will be billed secondarily.
- That all copays and payments toward deductibles are due on the day of service. If the insurance plan changes to a plan Eyecare of Lehi is not a participating provider, the patient or minor patient's guardian is responsible for the charges.
- That I agree that I am directly and fully responsible to the optometrist for payment of all charges. **I realize that if my insurance company fails to pay its anticipated balance in full or payment is not made within 60 days, it is my responsibility to pay the doctors' bill.**
- That Medicare does not cover the refraction portion of the eye examination and I am responsible for the refraction fee today.
- ***That ophthalmic lenses are individually, custom made. Any orders for glasses lenses or contact lenses will not be refunded after the order has started processing. All lenses start processing within the hour of purchase.***
- That all ***professional fees are NON-REFUNDABLE***, including comprehensive eye exam, specialty testing, and contact lens fitting fees.
- That most contact lens services are not considered medically necessary by insurance and fees are usually not fully covered by insurance. I am responsible for any contact lens fees, prescription renewal fees, and/or training fees.
- That a contact lens fitting/refitting fee of $60-129 will be charged, unless a different fee is dictated by my insurance. This fee includes a recommendation of initial contact lenses based on measurements taken during my exam. It also includes the first 30 days of progress check appointments. A week/month supply of soft trial lenses, as well as training related to wearing them, will be supplied. Medically Necessary contact fittings range from $565-$989
- That the cost of a one-year supply of contacts is dependent on the type of lens the doctor prescribes. If the doctor prescribes a more complex lens, there will be an additional charge. Eyecare of Lehi competes in pricing of daily disposable contact lenses with all USA based, FTC approved companies and **will price match after rebates. Price matching must occur at the time of order.**
- That full payment is required prior to ordering contacts and that contact lens prescriptions usually expire in one year.

Patient: _____ Date: _____

Signature (Guardian signature if under 18): _____