PATIENT HISTORY FORM

LOGAN EYE INSTITUTE™

Patient Name:_____ **DOB**:_____ **SS#**_____
Primary Care Physician:_____ **Tobacco Use**: Y / N **Alcohol use**: Y / N **Drugs**: Y / N
***Medication Allergies**:_____ ***Latex Allergy**: Y / N ***Anesthesia Allergy**: Y / N
***Previous Surgeries in the last 5 years**: _____

Review Of Systems: Do You **Currently** Have These Symptoms/Diseases					
System		**Yes/No**	**System**		**Yes/No**
Constitutional:	Fever	Y N	**Gastrointestinal:**	Diarrhea	Y N
	Weight Loss	Y N		Upset Stomach	Y N
	Chills	Y N		Constipation	Y N
	Poor Vision	Y N		Kidney Failure	Y N
	Loss of Vision	Y N	**Endocrine:**	Diabetes type 1 or 2	Y N
	Eye Pain	Y N		Thyroid Disease: Low /High	Y N
	Tearing	Y N	**Neurological:**	Headache	Y N
	Redness	Y N		Seizure	Y N
	Jaw Pain	Y N		Stroke	Y N
	Amaurosis Fugax	Y N		Paralysis	Y N
	Scalp Tenderness	Y N	**Psychiatric:**	Anxiety	Y N
ENT:	Stuffy Nose	Y N		Depression	Y N
	Ear Ache	Y N		Insomnia	Y N
	Cough	Y N	**Integumentary:**	Rash	Y N
	Dry Mouth	Y N		Changing Moles	Y N
Respiratory:	Congestion	Y N	**Musculoskelatal:**	Joint Pain	Y N
	Wheezing	Y N		Stiffness	Y N
	Shortness of Breath	Y N		Arthritis	Y N
Cardiovascular:	Chest Pressure or Discomfort	Y N	**Hematologic:**	Bleeding	Y N
	Irregular Heartbeat/Palpitations	Y N		Anemia	Y N
	High Blood Pressure	Y N	**Allergic:**	Seasonal Allergies	Y N
	Heart Disease	Y N		Hay Fever	Y N
	Pacemaker/Defibrillator	Y N		Hives	Y N
	High Cholesterol	Y N	**CANCER OR TUMOR:**		Y N
PREGNANT OR PLANNING PREGNANCY		Y N	**NURSING**		Y N

***Current Medication List Including Supplements:**

_____
_____
_____
_____

Eye History: **Glasses Use:** Y / N **Contact Use:** Y / N **Double Vision:** Y / N **Glares and Halos:** Y / N
Eye Injury: Y / N **Eye Disease:** Y / N Explain:_____

Family History: Please list family members with this disease

Y / N Diabetes: _____ Y / N Hypertension: _____
Y / N Cataracts:_____ Y / N Glaucoma:_____
Y / N Cancer:_____ Y / N Macular Degeneration: _____
Y / N Heart disease:_____ Y / N Other eye problems: _____

Patient Signature:_____ **Date:**_____

Physician Signature:_____ **Date:**_____

PATIENT REGISTRATION FORM

LOGAN EYE INSTITUTE™

Today's Date: _____

Patient information

Last name : _____ **First name:** _____ **Middle name:** _____

Address: _____
Street/PO Box City State Zip

Home Phone: ( ) _____ **Cell:** ( ) _____ **Email:** _____

Marital Status: Single / Married / Divorced / Widowed / Other

Birth Date: _____ **Sex:** M / F **SS#:** _____

Language: _____ **Race:** _____ **Ethnicity:** Hispanic or Latino / Non-Hispanic or Latino

Contact information

In addition to myself, I designate the following individual(s) as **my personal representative/emergency contact** and grant associates of Logan Eye Institute permission to disclose (written or verbal) my protected health information to the individual(s) named below.

_____
Name of representative/Responsible Party Relationship to patient Contact phone #

_____
Name of representative/Responsible Party Relationship to patient Contact phone #

- Do we have permission to leave appointment information on your answering machine or with family members? **YES / NO**
- Do we have permission to leave test results/surgery information on your answering machine/with family members? **YES / NO**

☐ I choose not to designate any other person as my personal representative. I understand that I may revoke this authorization by written notice at any time.

Insurance Information – Must bring insurance card(s), we will take a copy at the front desk.

Primary Insurance Co.: _____
Name of Policy Holder: _____
Policy Holder's DOB: _____
ID#: _____
Group Number: _____
Employer: _____

Second Insurance Co.: _____
Name of Policy Holder: _____
Policy Holder's DOB: _____
ID#: _____
Group Number: _____
Employer: _____

Vision insurance: ☐ **VSP** ☐ **EyeMed** ☐ **Spectera** ☐ **Opticare** ☐ **Blue Vision** ☐ **Other** _____ ☐ **None**

How did you hear about us?

Did a physician refer you? YES / NO If yes, physician's name: _____

☐ LoganEyeInstitute.com ☐ Facebook ☐ Cache Valley Direct Savings-Guide
☐ Newspaper ☐ Phonebook ☐ Radio ☐ Insurance ☐ Other: _____
☐ Friends/family _____

May we use your name in thanking this person? YES / NO

Signature of Patient / Responsible Party: _____

Responsible Party Name (if not the patient): _____ Responsible Party DOB: _____

Relationship: _____ SS#: _____

Thank you for filling out your patient information!

LOGAN EYE INSTITUTE FINANCIAL POLICY

This is an agreement between Logan Eye Institute, as a creditor, and the Patient/debtor named on this form. In this agreement the words "you," "your," and "yours" mean the Patient/ Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we," "us," and "our" refer to Logan Eye Institute.

By executing this agreement, you are agreeing to pay for all services that are received.

Refractions: Refraction is the process of determining the eye's refractive error or need for corrective spectacles or contact lenses. It is an essential part of an eye examination, but is not a covered service by Medicare or most insurance's. If it is not a covered benefit through your insurance, you will be billed a $30 refraction fee.

Insurance: Logan Eye Institute provides services to you, not your insurance company. Because of this fact, you are responsible for payment of any bill incurred in this office. As a courtesy to you, we will bill your primary and secondary insurance company. If we have not received payment from your insurance within 60 days of service, you will be responsible for paying your balance in full. You are responsible for all deductibles and charges not covered by Insurance. Please understand that as a third party, we cannot become involved in a prolonged insurance negotiation. That is your responsibility. Please contact your insurance company to inquire if we are a participating provider. All required co-payments must be made at the time of service. We accept cash, personal check, and most major credit cards. If you have medical insurance but are unable to provide a copy of your insurance card, you will need to pay for your exam on the day of service. A day of service discount will be applied.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show each date of service, a description of the services rendered, the charges, any payments made by you or your insurance, and your current balance.

Payments: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the end of the month.

Charges to Account: We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service.

Divorce: In the case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible of the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Self-Pay: You are responsible for the full amount of the exam. A day of service discount will be available, only if you pay on the day of service. Otherwise you will be responsible for the full amount of the exam and will not receive the day of service discount.

Returned checks: There is a fee (currently $25) for any checks returned by the bank.

Liabilities: In the event that payment in full for charges incurred was not made, patient and the undersigned, if other than the patient, each jointly and severally agree to pay interest at the rate of 18% annually on all past due balances from the original due date, plus court cost and reasonable attorneys' fees, with or without suite, incurred in collecting any past due balance, and a collection fee if my account is assigned to a collection agency. I authorize the release of financial identifiable information concerning my account (including charges billed, payments made, and interest charges assessed, etc.) to the physician's collection agency or collection attorney should collection procedures as described become necessary.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions listed in this agreement and the financial policy will be in full force and effect.

I certify that I have accurately filled out the patient and insurance information form. I grant my permission to Logan Eye Institute and their assignee to telephone me at home or at my workplace to discuss matters relating to the Financial Policy. I certify that I have read and understand the Financial Policy and I hereby agree to abide by the conditions outlined therein.

Signature of Responsible Party: _____ Date: _____

Acknowledgement: Receipt of Logan Eye Institute's Notice of Privacy Practices: I acknowledge that I received the Notice of Privacy Practices from Logan Eye Institute.

Patient's name (please print): _____

Responsible Party's Name (if not the patient): _____

Signature of Responsible Party: _____ Date: _____