

Mount Ogden Eye Center
4360 Washington Blvd.
Ogden, UT 84403
(801) 476-0494



Bountiful Hills Eye Center
1551 S. Renaissance Towne Dr., #340
Bountiful, UT 84010
(801) 677-1122

MOUNT OGDEN/BOUNTIFUL HILLS EYE CENTERS PATIENT REGISTRATION FORM

PATIENT INFORMATION

Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Email Address _____

Phone: Home: _____ Cell: _____

Date of Birth: _____ Gender: Male Female

Social Security Number: _____

Marital Status: _____ Spouse's Name: _____

Emergency Contact: _____ Phone# _____

Family Doctor: _____

Pharmacy of Choice: _____ Phone #: _____

Location: _____

Person Responsible for Account If Other Than Self:

Name: _____ Relationship: _____

Birthdate: _____ SSN: _____

Employer: _____

Whom may we thank for referring you? _____

TODAY'S DATE: _____

Employment Information

Employer: _____

Address: _____

Phone: _____

Occupation: _____

Insurance Information

Primary Medical Insurance: _____

Policy # _____ Group # _____

Policy Holder: _____

Relationship: _____ DOB _____

SSN _____ Employer: _____

Secondary Medical Insurance:

Policy # _____ Group # _____

Policy Holder: _____

Relationship: _____ DOB _____

SSN _____ Employer: _____

Do you have one of these Vision Plans: (Circle)

VSP EYEMED SPECTERA OTHER _____

HIPPA DISCLOSURE – We are required to notify you of our privacy practices and have you sign that you have reviewed this information. Mount Ogden Eye Center and Bountiful Hills Eye Center maintain a record of each patient visit, describing your history, symptoms, exam findings, diagnosis, and suggested treatment. Medical records are needed to provide you with proper care, coordinate with other physicians involved with your care, and for communication with your insurance company. We do not share your personal medical information with any unauthorized entity without your permission. More details of our Notice of Privacy Practices in our written publication. Please let the receptionist know if you would like a copy to read before signing below.

I have received a copy of Mount Ogden/Bountiful Hills Eye Center Privacy Policy.

I do not wish to receive a copy of Mount Ogden/Bountiful Hills Eye Center Privacy Policy.

I would like to share my medical information with the following person(s):

Name _____ Relationship _____

Name _____ Relationship _____

I have received a copy of the Financial Policy. By signing this document, I agree to the terms of same and understand that this is a lifetime signature.

By signing this document, I confirm my information to be correct.

Signature

Employee's initials _____



WRITTEN EXPLANATION OF ARBITRATION

1. A binding arbitration agreement requires a patient to submit all future medical malpractice claims to arbitration instead of having those claims heard in a court by a judge or jury.
2. An arbitrator is a person chosen to resolve disputes after hearing the information presented by both sides. A panel of three arbitrators will hear the information presented by both sides and then render a final decision. You select an arbitrator, your doctor selects an arbitrator, and you and the doctor agree on a third arbitrator. In the event we cannot agree, the third arbitrator will be selected by the other two arbitrators from a court-issued list of arbitrators. You and your doctor may also agree that the dispute be heard by only one arbitrator.
3. You pay for the fees and expenses of your arbitrator, the doctor pays for his or her arbitrator, and the fees and expenses of the third arbitrator are shared equally. Should the parties agree that only one arbitrator be selected, the parties will equally share the fees and expenses of the arbitrators.
4. You have the right, at your expense, to be represented in arbitration by an attorney.
5. By choosing arbitration, you also have the right to require mediation. Mediation occurs before arbitration. Mediation is a process by which a neutral person tries to help the parties reach a mutually agreeable resolution of their dispute. The cost of mediation is shared equally.
6. Whether you sign the arbitration agreement or not is up to you. You will not be treated any differently if you choose not to sign the agreement.
7. You have the right to rescind the agreement within ten (10) days of signing the agreement.
8. The arbitration agreement is automatically renewed each year unless it has been cancelled in writing before the renewal date.
9. You have the right to have all of your questions about arbitration answered.

I have read and understand the foregoing Written Explanation of Arbitration and agree to the terms outlined. I have had the opportunity to ask questions and have my questions answered.

_____ **I have received a copy of the complete Arbitration Agreement.**

_____ **I have declined a copy of the complete Arbitration Agreement.**

Name of Patient (Print)

Signature of Patient or Patient's Representative

Date (MM/DD/YYYY)