OREM EYE CLINIC
742 N 530 E
OREM, UT 84097
801-224-4799

SOLOMON CAMPBELL, O.D.

eyecare@oremeyeclinic.com

PATIENT INFORMATION

TODAY'S DATE: ____/___/_____

LAST NAME: _____ **FIRST NAME**: _____ **MI**: _____

DATE OF BIRTH:____/____/_____ **SOCIAL SECURITY #** _____ **GENDER**: M / F

ADDRESS: _____ **Apt#**_____ **CITY**: _____ **STATE**: _____ **ZIP**:_____

CELL PHONE: _____-_____-_____ **HOME PHONE**: _____-_____-_____ **EMAIL**: _____

OKAY TO TEXT? Y / N **PREFERRED NAME:**_____

EMERGENCY CONTACT: _____ **PHONE NUMBER**:_____-_____-_____

Responsible Party Information (if different from patient)

LAST NAME:_____ **FIRST NAME**_____ **DATE OF BIRTH**:____/____/_____

SSN _____ **RELATIONSHIP TO PATIENT**:_____ **PHONE NUMBER**:_____-_____-_____

ADDRESS_____ **CITY**: _____ **STATE**_____ **ZIP**:_____

Medical Insurance:_____ **Policy Number**:_____

Vision Insurance: VSP/ Eyemed/**Other**:_____ **Policy Number**:_____

HIPAA AGREEMENT

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that required the creation of national standards to protect sensitive patient health information from being disclosed without the patient's consent or knowledge. The US Department of Health and Human Services (HHS) issued the HIPAA Privacy Rule to implement the requirements of HIPAA. Every healthcare provider, regardless of size of practice, who electronically transmits health information in connection with certain transactions are subject to the Privacy Rule and considered covered entities. These transactions include claims, benefit eligibility inquiries, referral authorization requests, and other transactions for which HHS has established standards under the HIPAA Transactions Rule.

A full copy of Notice of Privacy Practices was made available to me.

X **SIGNED**:_____ **DATE**:____/____/_____

Please fill out the release below with the name of anyone (spouse, parent, significant other etc…) who may call on your behalf to access any of your personal information (ie- billing inquiries, prescription/receipt request, insurance questions etc...)

RELEASE OF PROTECTED INFORMATION

I,_____ HEREBY AUTHORIZE OREM EYE CLINIC TO DISCUSS AND RELEASE MEDICAL OR INSURANCE INFORMATION, REGARDING MY CARE, OR FINANCIAL OBLIGATIONS FOR CARE, TO _____, UNTIL I RELINQUISH AUTHORIZATION BY VERBAL OR WRITTEN REQUEST.

X SIGNED:_____ **DATE**:_____/_____/_____

OREM EYE CLINIC
742 N 530 E
OREM, UT 84097
801-224-4799

SOLOMON CAMPBELL, O.D.

eyecare@oremeyeclinic.com

MEDICAL EXAM vs VISION EXAM

Many **problems with the eyes are medical in nature**. If you have any eye problems you need addressed during your visit (cataracts, diabetes, dry eyes, eye allergies, macular degeneration, etc), **we will bill your medical insurance**. If during your eye exam we discover a medical condition that must be cared for (patient education, referral, letters written to other doctors, medication or other treatment), we will bill your medical insurance, not your vision plan.

You can utilize a **Vision Plan** for a routine/wellness eye exam. This includes a glasses prescription and a thorough health check of your eyes. Management of medical conditions will require scheduling another visit.
Your wellness exam **requires a copay for the exam, and payment for Optos retinal photos.**
If you pay at time of service the photos are discounted 20%.

We bill this way to follow insurance requirements; we will inform you as to how we are billing on the day of your visit.

****

FINANCIAL POLICIES

1. **We are OUT OF NETWORK with Select Health/Med, Davis, Spectera, BlueView, FEP Blue, EPO, In-Focus, Opticare, Superior & some other insurance plans.** Please request itemized receipts if you would like to submit for "out of network" benefits.
2. **We are in network with many MEDICAL insurance plans, and with most VSP and EyeMed VISION plans.** Your financial obligation is determined by your insurance plan's actual benefits/allowances. Estimates & eligibility are not a guarantee of payment; final determination is made when your claim is processed by your insurance.
3. **We do NOT bill secondary insurance plans**, but we will provide you with itemized receipts to submit yourself.
4. **Contact Lens Evaluation costs $80-$200 for routine fittings. Many insurances discount this fee.** All patients wanting a contact lens prescription must have a contact lens evaluation and proper follow up prior to the release of a final prescription**.** This includes medical biomicroscopic examination, pertinent patient education, dry eye screenings, contact lens material and parameter changes as necessary, and visual acuity measurements to ensure good ocular health, proper fit of the contact lens, and optimal vision. **Read and sign at the bottom to acknowledge our method of providing you a copy of your contact lens prescription.** If follow up is not completed within 60 days of the original exam, you will be charged for additional services. If you experience discomfort, pain, irritation of any kind, or sudden blurred vision with your contact lenses, please call our office immediately.
5. Professional services, products, and glasses are **non-refundable**.
6. Prescription rechecks are $50 if more than 90 days after the original exam. Medical fees will apply if medical conditions are deemed the cause of vision problems.
7. We charge $10 to adjust and $50 to troubleshoot glasses if purchased outside of our office.
8. I authorize the release of information to insurance or other third-party carriers and direct them to remit payment directly to Orem Eye Clinic.
9. Patients are financially responsible for all co-pays, deductibles, coinsurance, and charges denied by insurance.
10. Insufficient funds will be charged an additional $35 fee.
11. If the account is not paid in full within 90 days, a 1.5% interest charge per month (18% annual interest) will be applied. If it becomes necessary to refer the account to a collection agency, there will be additional collection fees of up to 50% of the principal balance owing. Patients will be responsible for all attorney's fees and court costs incurred, should legal action become necessary.

By signing this I acknowledge that**:** I have read & been offered a copy of the Notice of Privacy Practices; I agree to the Medical Exam vs Vision Exam and Financial Policies above; I am responsible for any amount not paid by insurance, including copays and deductibles; Orem Eye Clinic will charge me up to $25 for missed appointments; and I acknowledge that I will receive a physical or electronic copy of my final contact lens prescription, once authorized by the prescriber.

SIGNATURE: _____PRINTED NAME: _____, _____ DATE: ___/___/_____
Patient (18 or older) or legal guardian **Last** **First**

OREM EYE CLINIC
742 N 530 E
OREM, UT 84097
801-224-4799

SOLOMON CAMPBELL, O.D.

eyecare@oremeyeclinic.com

PERSONAL HEALTH INFORMATION

PATIENT NAME: _____ DOB_____/_____/_____ GENDER: M / F

PRIMARY CARE PHYSICIAN: _____ DATE LAST SEEN: _____
PLEASE LIST ALL YOUR CURRENT MEDICATIONS (INCLUDE OVER THE COUNTER, VITAMINS, AND HERBAL THERAPIES):

_____

_____

LIST ALL MAJOR SURGERIES (INCLUDE ALL EYE SURGERIES): _____

_____

PLEASE LIST *ALL* MEDICATION ALLERGIES: _____

_____

REVIEW OF SYSTEMS

Please mark below if you have or ever had problems with the following conditions:

Allergic/immunologic
☐ None
☐ Lupus (SLE)
☐ Rheumatoid Arthritis
☐ Tract Infection
☐ Seasonal Allergies
☐ Other_____

Ear, Nose, And Throat
☐ None
☐ Sinusitis
☐ Upper Respiratory
☐ Acid Reflux/Ulcer
☐ Other_____

Gastrointestinal
☐ None
☐ Crohn's Disease
☐ Colitis
☐ Other_____

Skin/Integument
☐ None
☐ Eczema
☐ Rosacea
☐ Environmental Allergies
☐ Other _____

Psychiatric
☐ None
☐ Depression
☐ Bipolar
☐ Schizophrenia
☐ Other_____

Cardiovascular
☐ None
☐ High Blood Pressure
☐ Heart Disease
☐ Stroke
☐ Vascular Disease
☐ High Blood Cholesterol

Endocrine/Glands
☐ None
☐ Diabetes
☐ Hormone Dysfunction
☐ Thyroid Dysfunction
☐ Other_____

Respiratory
☐ None
☐ Asthma
☐ Bronchitis
☐ Emphysema
☐ Other_____

Muscle/Skeletal
☐ None
☐ Arthritis
☐ Fibromyalgia
☐ Ankylosing Spondylitis
☐ Other_____

Genital/Urinary
☐ None
☐ Urinary Tract Infection
☐ HIV Positive
☐ Herpes/Chlamydia
☐ Other_____

Hematologic/Lymphatic
☐ None
☐ Anemia
☐ Leukemia
☐ Bleeding Disorder
☐ Other_____

Neurological
☐ None
☐ Multiple Sclerosis
☐ Epilepsy
☐ Tremors
☐ Other_____

General Health
☐ None
☐ Weight loss/gain
☐ Fever
☐ Fatigue
☐ Trauma
☐ Other_____

Social History
Tobacco Use: ☐Current Smoker ☐Former Smoker ☐ Non-Smoker
Non-Prescription Drugs_____
Alcohol Consumption_____

PLEASE SIGN HERE TO ACKNOWLEDGE THIS INFORMATION IS UP TO DATE:

X **Signature: _____ Date:____/___/_____**

OREM EYE CLINIC
742 N 530 E
OREM, UT 84097
801-224-4799

SOLOMON CAMPBELL, O.D.

eyecare@oremeyeclinic.com

OCULAR HEALTH HISTORY

PATIENT NAME: _____ DOB_____/_____/_____ Date_____/_____/_____

REASON FOR TODAY'S VISIT:_____

*MARK ANY ADDITIONAL CONCERNS YOU HAVE:

- ☐ **VISUAL FRUSTRATION**
- ☐ **BURNING/GRITTINESS**
- ☐ **RED EYES / ITCH**
- ☐ **WATERING EYES**
- ☐ **LIGHT SENSITIVITY**
- ☐ **CONTACTS DISCOMFORT**
- ☐ **HEADACHE**
- ☐ **DOUBLE VISION**
- ☐ **FLASHES/SPOTS IN VISION**
- ☐ **EYE FATIGUE/STRAIN**
- ☐ **DIABETES**
- ☐ **GLAUCOMA CONCERN**
- ☐ **DROOPY LIDS/BROW**
- ☐ **NIGHT DRIVING**
- ☐ **CATARACTS/BOTHERSOME GLARE**
- ☐ **MACULAR DEGENERATION**
- ☐ **POOR DARK ADAPTATION**
- ☐ **TAKING MEDICATION FOR AUTOIMMUNE DISEASE**

DO YOU WEAR GLASSES? YES / NO DO YOU WEAR CONTACT LENSES? YES / NO

WOULD YOU LIKE TO HAVE A CONTACT LENS EVALUATION/PRESCRIPTION AT THIS VISIT? YES* / NO

***IF YES, YOU MUST REVIEW AND SIGN OUR CONTACT LENS NOTICE FORM**

INDICATE BELOW IF THE FOLLOWING APPLIES TO YOU OR A FAMILY MEMBER:

Blindness	Self /Family _____
Amblyopia or Eye Turn	Self /Family _____
Glaucoma	Self /Family _____
Macular Degeneration	Self /Family _____
Retinal Detachment	Self /Family _____
Other	Describe:_____

---------- *OFFICE USE ONLY BELOW THIS LINE* ---------- *OFFICE USE ONLY BELOW THIS LINE* ----------

- ☐ **OSDE TOPCON FULL**
- ☐ **TOPCON TOPO**
- ☐ **MG Imaging**
- ☐ **DYNAMIC CORNEA**
- ☐ **MAESTRO CORNEA**
- ☐ **TOPCON PUPILOMETRY**
- ☐ **OCTOPUS G TOP**
- ☐ **OCTOPUS M TOP**
- ☐ **OCTOPUS TAPED/UNTAPED**
- ☐ **CL TRAINING (SCL / RGP / SCLE**
- ☐ **OPTOS PLUS RETINA**
- ☐ **OPTOS AF**
- ☐ **ADAPT DX PRO**
- ☐ **MAESTRO WIDE**
- ☐ **MAESTRO ANGLE**