UTAH VALLEY
EYE CENTER

Utah Valley Physicians Plaza
1055 N. 300 W., Suite 204
Provo, Utah 84604
utahvalleyeye.com
Tel: (801) 357-7373 Fax: (801) 357-7217

WELCOME TO OUR OFFICE

PATIENT INFORMATION (PLEASE PRINT)

Last Name ____________________ First Name ____________________ Middle ____________________

Address ____________________ City ____________________ State ________ Zip ____________

Cell Phone ____________________ Alt Phone ____________________

SS#: ________-________-________ Birthdate: ______/______/______ Age ________ Gender: M / F

Marital Status: S M D W (Circle one) Race: Hispanic or not Hispanic/Latino (Circle one) Ethnicity: ____________________ Language: ____________________
(The above are required to comply with Federal Government requirements.)

Primary Physician ____________________ Emergency Contact ____________________ (____)____________________
Name Phone Number

RESPONSIBLE PARTY/POLICY HOLDER (If different than patient)

Last Name ____________________ First Name ____________________ Middle ____________________

Address ____________________ City ____________________ State ________ Zip ____________

SS#: ________-________-________ Birthdate: ______/______/______ Phone: ____________________

Relationship to Patient ____________________ Gender: M / F Marital Status: S M D W (Circle one)

INSURANCE INFORMATION

Name of Insured: ____________________ DOB: ______/______/______ SS#: ________-________-________

Primary Carrier: ____________________ Mem ID#: ____________________ Group # ____________________

Secondary Carrier: ____________________ Mem ID#: ____________________ Group # ____________________

IMPORTANT INSURANCE / PAYMENT INFORMATION

We will submit your insurance claim if we are given the proper information. It is your responsibility to pay any co-payment, deductible, coinsurance or any other balance not paid by your insurance company; the co-payment is expected at the time of service. If there are any problems with your insurance coverage, it is YOUR responsibility to resolve it with them. In the event that your insurance company refuses payment for services rendered, you will be responsible for payment in full. Refraction (the determination of your glasses or contact lens prescription) is, in many cases not covered by insurance and YOU will be responsible for the charge associated with this service. Payments on account billed are expected within 30 days. I agree that interest will accrue on all past-due amounts at the rate of 18% per annum (1.5 % per month) until paid in full. In the event any amount(s) is/are referred to a third party debt collection agency, I agree that in addition to any other amount(s) allowed by law, (interest, court costs, attorney's fees, etc.) I will also be responsible for a collection fee up to 40 % of the principal amount(s) owing as allowed by Utah Code Annotated, sec. 12-1-11. The terms of this paragraph shall apply to all amount(s) incurred by me or any individual for whom I have legal responsibility whether such amount(s) are incurred today or after today.

ASSIGNMENT OF BENEFITS AND INSURANCE AUTHORIZATION

I hereby assign all medical and/or surgical benefits including Medicare, Medicaid, private insurance and other health plans directly to Dr. Duane J. Nelson and/or Dr. L. Todd Cook and/or Dr. Michael J. Lloyd and/or Dr. Jeffrey P. Gardiner and/or Dr. Joe R. Haggard and/or Dr. Franklin M. Edmunds and/or Dr. Kristine Dunn and/or Blaine F. Bird and/or Dr. David O. Edmunds and/or Tosha H. Walker, D.N.P. and/or Julie Frischknecht, D.N.P. and/or Dr. Larry Noble for any services provided by him/her. I authorize the doctors listed above to furnish my insurance carrier any information regarding services rendered me by him/her. I have also read the Important Insurance/Payment Information policy above and agree to its terms.

____________________ ____________________ ______/______/______
Signature of Patient or Responsible Party Printed Name Date

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PATIENT NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be disclosed. **Please review it carefully**.

Utah Valley Eye Center will use your medical information for the following:

- **Treatment:** Including providing your medical records to consulting clinicians and insurance companies
- **Payment:** We will file necessary claims with insurance companies in your name to obtain payment. They may request part or all of your medical record to pay the claim.
- **Health Care Operations:** Any other involved in your health care

The entire "Notice of Privacy Practices for Utah Valley Eye Center Inc. is available for your perusal.

In conjunction with these privacy practices you will need to provide us with the following information:

Name of person(s) we may speak to regarding your health (i.e. Spouse, Child, etc.) including a contact number

______________________________ (_____) ______________

Name of Authorized Person(s)/Relationship — Contact Phone Number

______________________________ (_____) ______________

Name of Authorized Person(s)/Relationship — Contact Phone Number

CONSENT FOR TEXT MESSAGE AND EMAIL REMINDERS

Cell Phone Number: ______________________________ (circle one) Yes No

May we leave a message regarding your health, or an upcoming appointment? (circle one) Yes No

Consent for email reminders, correspondence, and an online access invitation to medical records

Email Address ______________________________ (circle one) Yes No

______________________________ ______________________________

Signature of Patient or Parent or Legal Guardian — Relationship to Patient

______________________________ _____ / _____ / _____

Print name (of above party) — Patient's Date of Birth

______________________________ _____ / _____ / _____

Witness-Office Staff — Date

ARBITRATION AGREEMENT

Article 1 <u>Dispute Resolution</u>

By signing this Agreement ("Agreement") we are agreeing to resolve any Claim for medical malpractice by the dispute resolution process described in this Agreement. Under this Agreement, you can pursue your Claim and seek damages, but you are waiving your right to have it decided by a judge or jury.

Article 2 <u>Definitions</u>

A. The term "we," "parties" or "us" means you, (the Patient), and the Provider.

B. The term "Claim" means one or more Malpractice Actions defined in the Utah Health Care Malpractice Act (Utah Code 78-14-3(15)). Each party may use any legal process to resolve non-medical malpractice claims.

C. The term "Provider" means the physician, group or clinic and their employees, partners, associates, agents, successors and estates.

D. The term "Patient" or "you" means:

  (1) you and any person who makes a Claim for care given to YOU, such as your heirs, your spouse, children, parents or legal representatives, AND

  (2) your unborn child or newborn child for care provided during the 12 months immediately following the date you sign this Agreement, or any person who makes a Claim for care given to that unborn or newborn child.

Article 3 <u>Dispute Resolution Options</u>

A. <u>Methods Available for Dispute Resolution.</u> We agree to resolve any Claim by:

  (1) working directly with each other to try and find a solution that resolves the Claim, OR

  (2) using non-binding mediation (each of us will bear one-half of the costs); OR

  (3) using binding arbitration as described in this Agreement.

  You may choose to use any or all of these methods to resolve your Claim.

B. <u>Legal Counsel.</u> Each of us may choose to be represented by legal counsel during any stage of the dispute resolution process, but each of us will pay the fees and costs of our own attorney.

C. <u>Arbitration – Final Resolution.</u> If working with the Provider or using non-binding mediation does not resolve your Claim, we agree that your Claim will be resolved through binding arbitration. We both agree that the decision reached in binding arbitration will be final.

Article 4 <u>How to Arbitrate a Claim</u>

A. <u>Notice.</u> To make a Claim under this Agreement, mail a written notice to the Provider by certified mail that briefly describes the nature of your Claim (the "Notice"). If the Notice is sent to the Provider by certified mail it will suspend (toll) the applicable statute of limitations during the dispute resolution process described in this Agreement.

B. <u>Arbitrators.</u> Within 30 days of receiving the Notice, the Provider will contact you. If you and the Provider cannot resolve the Claim by working together or through mediation, we will start the process of choosing arbitrators. There will be three arbitrators, unless we agree that a single arbitrator may resolve the Claim.

  (1) <u>Appointed Arbitrators.</u> You will appoint an arbitrator of your choosing and all Providers will jointly appoint an arbitrator of their choosing.

  (2) <u>Jointly-Selected Arbitrator.</u> You and the Provider(s) will then jointly appoint an arbitrator (the "Jointly-Selected Arbitrator"). If you and the Provider(s) cannot agree upon a Jointly-Selected Arbitrator, the arbitrators appointed by each of the parties will choose the Jointly-Selected Arbitrator from a list of individuals approved as arbitrators by the state or federal courts of Utah. If the arbitrators cannot agree on a Jointly-Selected Arbitrator, either or both of us may request that a Utah court select an individual from the lists described above. Each party will pay their own fees and costs in such an action. The Jointly-Selected Arbitrator will preside over the arbitration hearing and have all other powers of an arbitrator as set forth in the Utah Uniform Arbitration Act.

C. <u>Arbitration Expenses.</u> You will pay the fees and costs of the arbitrator you appoint and the Provider(s) will pay the fees and costs of the arbitrator the Provider(s) appoints. Each of us will also pay one-half of the fees and expenses of the Jointly-Selected Arbitrator and any other expenses of the arbitration panel.

D. <u>Final and Binding Decision.</u> A majority of three arbitrators will make a final decision of the Claim. The decision shall be consistent with the Utah Uniform Arbitration Act.

E. All Claims May be Joined. Any person or entity that could be appropriately named in a court proceeding ("Joined Party") is entitled to participate in this arbitration as long as that person or entity agrees to be bound by the arbitration decision ("Joinder"). Joinder may also include Claims against persons or entities that provided care prior to the signing date of this Agreement. A "Joined Party" does not participate in the selection of the arbitrators but is considered a "Provider" for all other purposes of this Agreement.

Article 5 Liability and Damages May Be Arbitrated Separately

At the request of either party, the issues of liability and damages will be arbitrated separately. If the arbitration panel finds liability, the parties may agree to either continue to arbitrate damages with the initial panel or either party may cause that a second panel be selected for considering damages. However, if a second panel is selected, the Jointly Selected arbitrator will remain the same and will continue to preside over the arbitration unless the parties agree otherwise.

Article 6 Venue / Governing Law

The arbitration hearings will be held in a place agreed to by the parties. If the parties cannot agree, the hearings will be held in Salt Lake City, Utah. Arbitration proceedings are private and shall be kept confidential. The provisions of the Utah Uniform Arbitration Act and the Federal Arbitration Act govern this Agreement. We hereby waive the prelitigation panel review requirements. The arbitrators will apportion fault to all persons or entities that contributed to the injury claimed by the Patient, whether or not those persons or entities are parties to the arbitration.

Article 7 Term / Rescission / Termination

A. Term. This Agreement is binding on both of us for one year from the date you sign it unless you rescind it. If it is not rescinded, it will automatically renew every year unless either party notifies the other in writing of a decision to terminate it.

B. Rescission. You may rescind this Agreement within 10 days of signing it by sending written notice by registered or certified mail to the Provider. The effective date of the rescission notice will be the date the rescission is postmarked. If not rescinded, this Agreement will govern all medical services received by the Patient from Provider after the date of signing, except in the case of a Joined Party that provided care prior to the signing of this agreement (see Article 4(E)).

C. Termination. If the Agreement has not been rescinded, either party may still terminate it at any time, but termination will not take effect until the next anniversary of the signing of the Agreement. To terminate this Agreement, send written notice by registered or certified mail to the Provider. This Agreement applies to any Claim that arises while it is in effect, even if you file a Claim or request arbitration after the Agreement has been terminated.

Article 8 Severability

If any part of this Agreement is held to invalid or unenforceable, the remaining provisions will remain in full force and will not be affected by the invalidity of any other provision.

Article 9 Acknowledgement of Written Explanation of Arbitration

I have received a written explanation of the terms of this Agreement. I have had the right to ask questions and have my questions answered. I understand that any Claim I might have must be resolved through the dispute resolution process in this Agreement instead of having them heard by a judge or jury. I understand the role of the arbitrators and the manner in which they are selected. I understand the responsibility for arbitration related costs. I understand that this Agreement renews each year unless cancelled before the renewal date. I understand that I can decline to enter into the Agreement and still receive health care. I understand that I can rescind this Agreement within 10 days of signing it.

Article 10 Receipt of Copy I have received a copy of this document.

Provider

Utah Valley Eye Center

Name of Physician, Group or Clinic	Name of Patient (Print)
By: Signature of Physician or Authorized Agent	Signature of Patient or Patient's Representative (Date)

(05/03/04)

medical information. You should submit your request in writing to our Privacy Officer. You may obtain a form from our Privacy Officer to make your request.

We may charge you reasonable, cost-based fees for a copy of your medical information, for mailing the copy to you, and for preparing any summary or explanation of your medical information you request. Contact our Privacy Officer for information about our fees.

Disclosure Accounting: You have the right to a list of instances after April 13, 2004 in which we disclose your medical information for purposes other than treatment, payment, health care operations, as authorized by you, and for certain other activities.

You should submit your request to the Privacy Officer. You may obtain a form from the Privacy Officer to make your request. We will provide you with information about each accountable disclosure that we made during the period for which you request the accounting, except we are not obligated to account for a disclosure that occurred more than 6 years before the date of your request and never for a disclosure that occurred before April 14, 2004. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to your additional requests. Contact our Privacy Officer for information about our fees.

Amendment. You have the right to request that we amend your medical information. You should submit your request in writing to the Privacy Officer. You may obtain a form from that contact to make your request.

We may deny your request only for certain reasons. If we deny your request, we will provide you a written explanation. If we accept your request, we will make your amendment part of your medical information and use reasonable efforts to inform others of the amendment who we know may have and rely on the unamended information to your detriment, as well as persons you want to receive the amendment.

Objection / Opt Out: You have the right to object to the disclosure of your medical information to your family, a relative, a close friend or any other person you identify.

Restriction: You have the right to request that we restrict our use or disclosure of your medical information for treatment, payment or health care operations, or with family, friends or others you identify. We are not required to agree to your request. If we do agree, we will abide by our agreement, except in a medical emergency or as required or authorized by law. You should submit your request to the contact at the end of this notice. You may obtain a form from that contact to make your request. Any agreement we may make to a request for restriction must be in writing signed by a person authorized to bind us to such an agreement.} Effective September 2013 we will agree to a restriction request if:

1. except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and not for purposes of carrying out treatment); and,
2. The medical information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full.

Confidential Communication: You have the right to request that we communicate with you about your medical information in confidence by means or to locations that you specify. Make your request in writing. Your request must represent that the information provided or requested could endanger you if it is not communicated in confidence. You should submit your request in writing to the Privacy Officer. You may obtain a request form from the privacy officer.

We will accommodate your request if it is reasonable, specifies the means or location for communicating with you, and continues to permit us to collect premiums and pay claims under your health plan. Please note that an explanation of benefits and other information that we issue to the subscriber about health care that you received for which you did not request confidential communications, or about health care received by the subscriber or by others covered by the health plan in which you participate, may contain sufficient information to reveal that you obtained health care for which we paid, even though you requested that we communicate with you about that health care in confidence.

Breach Notification: You have the right to receive notice of a breach of your unsecured medical information. Breach may be delayed or not provided if so required by a law enforcement official. You may request that notice be provided by electronic mail. If you are deceased and there is a breach of your medical information, the notice will be provided to your next of kin or personal representatives if the plan knows the identity and address of such individual(s).

Electronic Notice: This notice is posted on our website. You have the right to receive this notice electronically in a format requested by you or in written form. Please contact our Privacy Officer to obtain this notice in written form.

COMPLAINTS

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information, amending your medical information, restricting our use or disclosure of your medical information, or how we communicate with you about your medical information (including a breach notice communication), you may contact our Privacy Officer.

You also may submit a written complaint to the Office for Civil Rights of the United States Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, Washington, D.C. 20201. You may contact the Office for Civil Rights' Hotline at 1-800-368-1019.

We are committed to maintaining the privacy of your medical information. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office of Civil Rights.

CONTACT INFORMATION

For more information about our privacy practices, to discuss questions or concerns, or to get additional copies of this notice, please contact our Privacy Officer:

Privacy Officer: Michael Clayton
Telephone: (801) 852-9305
E-mail: mclayton@utahvalleyeye.com
Address: 1055 N. 300 W. Ste 204, Provo, Utah 84604

UTAH VALLEY
EYE CENTER

NOTICE OF PRIVACY PRACTICES
FOR
UTAH VALLEY EYE CENTER, INC.

Effective MAY, 2019

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

UTAH VALLEY EYE CENTER, INC.
Notice of Privacy Practices
Version 3.0 May, 2019

SUMMARY OF OUR PRIVACY PRACTICES

We may use and disclose your protected health information ("medical information"), without your permission, for treatment, payment, and health care operations activities. We may use and disclose your medical information, without your permission, when required or authorized by law for public health activities, law enforcement, judicial and administrative proceedings, research, and certain other public benefit functions.

We may disclose your medical information to your family members, friends, and others you involve in your care or payment for your health care with appropriate authorization. We may disclose your medical information to appropriate public and private agencies in disaster relief situations.

We will not otherwise use or disclose your medical information without your written authorization.

You have the right to examine and receive a copy of your medical information. You have the right to receive an accounting of certain disclosures we may make of your medical information. You have the right to request that we amend, further restrict use and disclosure of, or communicate in confidence with you about your medical information.

You have the right to receive notice of breaches of your unsecured medical information.

Please review this entire notice for details about the uses and disclosures we may make of your medical information, about your rights and how to exercise them, and about complaints regarding or additional information about our privacy practices..

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your protected health information ("medical information"). We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your medical information.

We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect September 2013 and will remain in effect unless we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make any change in our privacy practices and the new terms of our notice applicable to all medical information we maintain, including medical information we created or received before we made the change.

USES AND DISCLOSURES OF YOUR MEDICAL INFORMATION

Treatment: We may use and disclose your medical information for your treatment and to provide you with treatment-related health care services. For example, we may disclose your medical information to doctors, nurses, technicians and other personnel, including people outside the office, who are involved in your medical care and need the information to provide you with medical care.

Payment: We may use and disclose your medical information, without your permission, to pay claims from physicians, hospitals and other health care providers for services delivered to you that are covered by your health plan, to determine your eligibility for benefits, to coordinate your benefits with other payers, to determine the medical necessity of care delivered to you, to obtain premiums for your health coverage, to issue explanations of benefits to the subscriber of the health plan in which you participate, and the like. We may disclose your medical information to a health care provider or another health plan for that provider or plan to obtain payment or engage in other payment activities.

Operations: We may use and disclose your medical information for health care operations to make sure all our patients receive quality care and to operate and manage our office(s). For example, we may use health information to review our treatment and services and evaluate performance of our staff.

Other Plans: We may disclose your medical information to another health plan or to a health care provider subject to federal privacy protection laws, as long as the plan or provider has or had a relationship with you and the medical information is for that plan's or provider's health care quality assessment and improvement activities, competence and qualification evaluation and review activities, or fraud and abuse detection and prevention. If the health plan intends to use or disclose your medical information for underwriting purposes, it is prohibited from using or disclosing your genetic information for those purposes.

Appointment Reminders: We may use or disclose medical information to contact you to remind you that you have an appointment with us. Let us know if you do not want us to contact you regarding appointments or if you wish us to use a different number or address in reaching you for this purpose.

Your Authorization: You may give us written authorization to use your medical information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization, we will not use or disclose your medical information for any purpose other than those described in this notice.

Your authorization is required for uses and disclosure of psychotherapy notes, use and disclosure of your health information for marketing purposes and disclosures that constitute a sale of your medical information.

Family, Friends, and Others Involved in Your Care or Payment for Care: We may disclose your medical information to a family member, friend or any other person you involve in your care or payment for your health care with appropriate authorization. We will disclose only the medical information that is relevant to the person's involvement.

We may use or disclose your name, location, and general condition to notify, or to assist an appropriate public or private agency to locate and notify, a person responsible for your care in appropriate situations, such as a medical emergency or during disaster relief efforts.

We will provide you with an opportunity to object to these disclosures, unless you are not present or are incapacitated or it is an emergency or disaster relief situation. In those situations, we will use our professional judgment to determine whether disclosing your medical information is in your best interest under the circumstances.

We may disclose to your employer whether you are enrolled or disenrolled in a health plan that your employer sponsors.

We may disclose summary health information to your employer to use to obtain premium bids for the health insurance coverage offered under the group health plan in which you participate or to decide whether to modify, amend or terminate that group health plan. Summary health information is aggregated claims history, claims expenses or types of claims experienced by the enrollees in your group health plan. Although summary health information will be stripped of all direct identifiers of these enrollees, it still may be possible to identify medical information contained in the summary health information as yours.

Health-Related Products and Services: We may use your medical information to communicate with you about health-related products, benefits and services, and payment for those products, benefits and services that we provide or include in our benefits plan. We may use your medical information to communicate with you about treatment alternatives that may be of interest to you.

These communications may include information about the health care providers in our networks, about replacement of or enhancements to your health plan, and about health-related products or services that are available only to our enrollees that add value to our benefits plans.

Public Health and Benefit Activities: We may use and disclose your medical information, without your permission, when required by law, and when authorized by law for the following kinds of public health and public benefit activities:

- for public health, including to report disease and vital statistics, child abuse, and adult abuse, neglect or domestic violence;
- to avert a serious and imminent threat to health or safety;
- for health care oversight, such as activities of state insurance commissioners, licensing and peer review authorities, and fraud prevention agencies;
- for research;
- in response to court and administrative orders and other lawful process;
- to law enforcement officials with regard to crime victims and criminal activities;
- to coroners, medical examiners, funeral directors, and organ procurement organizations;
- to the military, to federal officials for lawful intelligence, counterintelligence, and national security activities, and to correctional institutions and law enforcement regarding persons in lawful custody; and
- as authorized by state worker's compensation laws.

YOUR RIGHTS

Access: You have the right to examine and to receive a copy of your medical information, with limited exceptions, in both written and electronic form held by us within 30 days of your request. We may refuse to copy your medical information to an unencrypted portable device. You have the right to request us to send your medical information electronically to whom you authorize. We will advise you of the risk of transmitting unencrypted