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. Paul F. Olson and/or 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 Dr. Blaine F. Bird and/or Tosha H. Walker, D.N.P and Dr. David O. Edmunds and/or Garret D. Bringhurst 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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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

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

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

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

_____ _____
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

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

By: _____

Signature of Physician or Authorized Agent

Name of Patient (Print)

Signature of Patient or Patient's Representative (Date)

(05/03/04)

ARBITRATION AGREEMENT

Article 1 Dispute Resolution

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 Definitions

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 Dispute Resolution Options

A. Methods Available for Dispute Resolution. 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. Legal Counsel. 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. Arbitration – Final Resolution. 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 How to Arbitrate a Claim

A. Notice. 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. Arbitrators. 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) Appointed Arbitrators. You will appoint an arbitrator of your choosing and all Providers will jointly appoint an arbitrator of their choosing.

(2) Jointly-Selected Arbitrator. 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. Arbitration Expenses. 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. Final and Binding Decision. A majority of three arbitrators will make a final decision of the Claim. The decision shall be consistent with the Utah Uniform Arbitration Act.