Welcome To Our Office

Dr. Kenneth E. Hooton
Dr. Lori K. Hooley

Date___________

Patient_______________________________________ BirthDate____________ Age________

Address______________________________ City______________________ ZIP_________

Home Phone______________ Work Phone_______________ E-mail_________________

Employer_____________________ Occupation______________ SSN_____________

Patient's Spouse(or Parent, if a minor)____
Place of employment of Spouse ______________________________ SSN______________
Place of employment of Parent_______________________________ SSN______________
Responsible Party (Guarentor)____________________ Driver's License #_____________

Insurance Information
Vision Care Ins:_____________________________ Policy Holder_____________________
ID #_____________________
Primary Medical:_____________________________ Policy Holder_____________________
ID#_____________________
Second Medical:_____________________________ Policy Holder_____________________
ID#_____________________
Other Insurance:_____________________________ Policy Holder_____________________
ID#_____________________

Insurance Signature on File: I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I authorize payment of these benefits directly to **Kenneth E. Hooton, O.D./Lori K. Hooley, O.D.** on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in Item 9 of the HCFA-1500 claim form or electronically submitted claim), my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above.

_______________________________ _______________
Lifetime Patient Signature *Date*

Thank you for selecting our office. Our goal is to provide you with the highest quality, state-of-the-art care.

--Please Read and SIGN the OTHER Side--

ClearViewVisionCenter
Kenneth E Hooton, O.D.
Lori K Hooley, O.D.
American Fork, UT 84003

Financial Policy

It is our policy that all examination fees will be paid at the time of your visit.

Glasses, contact lenses, and other products require a deposit when ordered, and payment in full at delivery.

Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. **You are responsible for payment, not your insurance. We provide services to you, not your insurance company.**

If you have questions about your coverage or eligibility, please contact your representative. <u>We cannot guarantee the accuracy of information given to us by your insurance</u>!!

Records can be released only upon a signed request by the patient. Current prescriptions will be released to optical companies at your request. Contact lens prescriptions are not considered complete until the three-month fitting is complete. Prescriptions expire either one or two years after the last comprehensive examination.

Discounts given for payment in cash upon delivery **will be cancelled** if we must bill you or your insurance, or if a check does not clear the bank. Interest at the rate of **1.5%** per month is billed after 90 days.

Should collection become necessary, I hereby expressly agree to pay all costs of collection including an additional fee up to 50% whether or not the account is turned to an outside collection agency. I further agree to pay all court costs and attorney fees should legal action become necessary.

I have read and understand the above information:

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Patient or Guarantor signature Date