UNGRICHT PARKER
Eye Associates

Patient Information Today's Date _____

Name _____ Birthdate _____ M / F Age _____
First Middle Last month / day / year Sex

Address _____ City _____ State _____ Zip _____

Home Phone # _____ Cell Phone # _____ Work Phone # _____

Social Security # _____ E-mail Address* _____
*This will only be used for appointment reminders

Employer/Occupation _____ If under 18, Guardian_____

Marital Status □ Single □ Married □ Divorced □ Widowed Spouse Name _____

Nearest Relative Not Living With You _____ Phone # _____

Emergency Contact _____ Phone # _____

Referred to Doctor By _____ Phone # _____

Insurance Information -if your insurance requires a referral from your primary care physician, you will need it today!

Primary Insurance _____ ID # _____ GROUP # _____

Name of Insured _____ DOB _____

Seconday Insurance _____ ID # _____ GROUP # _____

Name of Insured _____ DOB _____

Vision Insurance -for routine/non-medical exams, contacts, or glasses only --CANNOT be used for a medical problem--

Vision Insurance _____ ID # _____

Name of Insured _____ DOB _____ Last 4 of social _____

Payment Policy

By signing below, I understand that it is my responsibility to provide my correct/updated insurance information and that this office will bill my insurance. I understand that any co-pay, deductible, refraction, or other balance not covered by insurance are due at the time of service. This includes glasses, contact lenses, and evaluation fitting fees. Regardless of insurance coverage, I agree that it is and shall remain my responsibility to pay all amounts owing within 30 days of the service date. Any amount not paid within 90 days will be referred to a third party debt collection agency, with interest accruing on all past due amounts at the rate of 18% per annum (1.5% per month) until paid in full. In addition to any other amounts allowed for by law, (such as interest, court costs, reasonable attorney's fees, etc.) I will also be responsible for a collection fee of up to 33.3% of the principal amount owing as allowed by Utah Code. The terms of this paragraph shall apply to all amounts incurred by me or by any individual for whom I have legal responsibility today or in the future. I further understand that if I fail to give 24 hours notice when cancelling or rescheduling an appointment, I may be charged a $35 fee. I authorize the release of any medical or other information necessary to process this claim to Ungricht Parker Eye Associates and/or Regis Optical. I also request payment be made from my insurance to the aforementioned parties.

5/17/2016 Signature _____ Relationship _____