Insurance Disclaimer:
I acknowledge that no guarantee can be made to me regarding the coverage of my care. Claims are not determined until they are received by my insurance. Any benefit description given to me is only an estimate. I am responsible to confirm eligibility and benefits for my care.

Refraction Notice:
Please be aware that patients are responsible for the cost of refractions when a vision prescription is issued. A refraction includes the measurement and testing that is required to issue a vision prescription for glasses or contacts and is typically performed during all comprehensive/annual exams**. The charge for this testing is $42** and is not covered by Medicare or medical insurance providers.

Please contact your insurance provider for further information on items covered by your individual plans.

Notice of Privacy Practices (HIPAA Notification)
I acknowledge that I have been given or offered a copy of The Eye Institute of Utah's Notice of Privacy Practices (HIPAA) to read and review.

Patient Representative
This section allows you to choose a patient representative(s) (a designated person(s) authorized by you) that allows The Eye Institute of Utah to disclose/share your medical information (Example: spouse, parent, family member, or any person of your choice).

[ ] I DO NOT wish to select a patient representative(s) at this time.
[ ] I DO wish to select a patient representative(s) at this time.

Designated Representative	Relation to Patient	Phone Number

My signature below acknowledges that I, _____ (print patient name), give my authorization for The Eye Institute of Utah to disclose any and all medical information pertaining to my care to the above named representative(s). I understand that I can withdraw my consent in writing at any time.

By signing below, I certify that I received or was offered and declined a copy of this information and I understand and acknowledge all the disclosures described in this document.

Signature _____

Date _____