Clayson Williams
EYE CENTER

DISEASES AND SURGERY OF THE EYE

Brice J. Williams, M.D., Ph.D.
Taylor W. Linton, O.D.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY RIGHTS

Please print Name _____

I have reviewed a copy of this offices Notice of Privacy Practices.

Signature _____

Date _____

List of those who have my permission to have access to my medical information.

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

4403 Harrison Blvd. Ste. 3600 Ogden, UT 84403
Phone 801.387.3550 Fax 801.387.3559

Clayson-Williams Eye Center
Brice J. Williams, MD, PhD
Taylor W. Linton, OD
4403 Harrison Blvd., Suite 3600, Ogden, UT 84403
Office: (801) 387-3550 Fax: (801) 387-3559

Patient Information

Date: _____

Name: _____
Last First Middle

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employer: _____ Date of Birth: _____ Age: ____ SSN: _____-_____-_____

Sex: Male or Female Marital Status: Single Married Divorced Widowed

Language: _____ Race: _____ Ethnicity: _____

Email Address: _____

Pharmacy: _____ Location: _____

Primary Care Physician: _____ Phone: _____

Referred by: _____

Primary Insurance

Insurance: _____ ID: _____ Group: _____

Policy Holders Name: _____ DOB: _____ Sex: _____

Relationship to Insured: _____ Policy Holders Employer: _____

Second Insurance

Insurance: _____ ID: _____ Group: _____

Policy Holders Name: _____ DOB: _____ Sex: _____

Relationship to Insured: _____ Policy Holders Employer: _____

Proceed to the Backside 

Emergency Contact (Emergency phone number must be different than patient phone number)

Name: _____ Relationship to Patient: _____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Authorization for Treatment and Financial Agreement:

I authorize treatment of the person named as patient and agree to pay for all services rendered to patient including but not limited to any amounts not paid by my insurance company. I will be responsible for all copayments, deductibles, coinsurance, refraction fees and/or non-covered services. I request payment of authorized benefits to the Clayson/Williams Eye Center on my behalf for any services furnished to me by Brice J Williams MD, PhD and Taylor W. Linton, OD. I authorize the Clayson/Williams Eye Center to release to my insurance company any information needed to determine benefits for my services.

TERMS AND CONDITIONS:

All delinquent accounts will be charged an interest rate of 1.5% per month (18% per annum). In the event any balance is not paid as agreed, the undersigned agrees to pay all collection fees. In the event of a lawsuit to collect the unpaid balance, the undersigned further agrees to pay court costs and reasonable attorney fees. You agree, in order for us to service our account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or e-mails, using any email address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

I/We have read this disclosure and agree to terms listed above.

Signature: _____ Date: _____

Print Name: _____

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 Providers.

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 Providers 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 the three arbitrators will make a final decision on 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 be 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 and I have been verbally encouraged to read it and this Agreement. I have had the right to ask questions, I have been verbally encouraged to ask any questions, and I have had all 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.

Providers Brice J. Williams, M.D., PhD, P.C.
Fred E. Clayson, M.D.
Taylor W. Linton, O.D.

_____ _____

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

(06/2011)

form # 1105

Name _____

PLEASE FILL OUT ENTIRE PAGE COMPLETELY

Eyes

Previous Surgery	☐ Yes	☐ No
Contact Lens	☐ Yes	☐ No
Pain	☐ Yes	☐ No
Double Vision	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No
Macular Degeneration	☐ Yes	☐ No
Dry Eyes	☐ Yes	☐ No
Redness	☐ Yes	☐ No
Burning	☐ Yes	☐ No
Watery eyes	☐ Yes	☐ No
Tired eyes	☐ Yes	☐ No

Ears, Nose & Throat

Hard of Hearing	☐ Yes	☐ No
Ringing in Ears	☐ Yes	☐ No
Vertigo	☐ Yes	☐ No

Cardiovascular

Chest Pain	☐ Yes	☐ No
Dizziness	☐ Yes	☐ No
Fainting Spells	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No
Irregular Heartbeat	☐ Yes	☐ No
Difficulty Lying Flat	☐ Yes	☐ No

Constitutional

Fatigue/Weakness	☐ Yes	☐ No
Fever	☐ Yes	☐ No
Weight Gain/Loss	☐ Yes	☐ No
Fall Risk	☐ Yes	☐ No

Respiratory

Cough	☐ Yes	☐ No
Congestion	☐ Yes	☐ No
Wheezing	☐ Yes	☐ No
Asthma	☐ Yes	☐ No

Gastrontestinal

Heartburn	☐ Yes	☐ No
Nausea/Vomiting	☐ Yes	☐ No
Jaundice/Hepatitis	☐ Yes	☐ No

Genito-Urinary

Pain/Difficulty	☐ Yes	☐ No
Blood in Urine	☐ Yes	☐ No
History of Kidney Stones	☐ Yes	☐ No
History of STD's	☐ Yes	☐ No

Psychiatric

Anxiety/Depression	☐ Yes	☐ No
Mood Swings	☐ Yes	☐ No
Diffficulty Sleeping	☐ Yes	☐ No

Endocrine

Increased Thirst	☐ Yes	☐ No
Increased Hunger	☐ Yes	☐ No
Increased Urination	☐ Yes	☐ No
Increased Sweating	☐ Yes	☐ No
Fingernail Changes	☐ Yes	☐ No

Blood/Lymphnodes

Easy Bruising	☐ Yes	☐ No
Gums Bleed Easily	☐ Yes	☐ No
Prolonged Bleeding	☐ Yes	☐ No
Heavy Aspirin Use	☐ Yes	☐ No

MusculoSkeletal

Stiffness	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No
Joint Pain/Swelling	☐ Yes	☐ No

Skin

Rash/Sores	☐ Yes	☐ No
Lesions	☐ Yes	☐ No
Hives/Eczema	☐ Yes	☐ No

Neurological

Seizures	☐ Yes	☐ No
Weakness/Paralysis	☐ Yes	☐ No
Numbness	☐ Yes	☐ No
Tremors	☐ Yes	☐ No

Immunologic

Hives	☐ Yes	☐ No
Itching	☐ Yes	☐ No
Runny Nose	☐ Yes	☐ No
Sinus Pressure	☐ Yes	☐ No
Influenza Received	☐ Yes	☐ No
Pneumonia Received	☐ Yes	☐ No

Allergies _____

Past Eye History

_____
_____
_____
_____
_____

Past Eye Surgeries

_____
_____
_____
_____
_____

Current Eye Medications

_____
_____
_____
_____
_____

SEE OTHER SIDE

Past Medical History

Diabetes ☐ Yes ☐ No
Hypertension ☐ Yes ☐ No
Heart Disease ☐ Yes ☐ No
Kidney Disease ☐ Yes ☐ No
Cancer ☐ Yes ☐ No
If yes, what type?

_____
_____
_____
_____

Past Surgeries ☐ Yes ☐ No

If yes, what surgeries:

_____
_____
_____
_____
_____
_____
_____
_____

Current Medications

Blood Thinners ☐ Yes ☐ No
Diabetic Medication ☐ Yes ☐ No
Other Medications ☐ Yes ☐ No
If yes, please list:

_____
_____
_____
_____
_____
_____

Family History

Diabetes	☐	Blindness	☐	Arthritis	☐
Cancer	☐	Cataracts	☐	Lazy Eye	☐
Heart Disease	☐	Glaucoma	☐	Other/Explanation	☐
Stroke	☐	Macular Degeneration	☐		
TB	☐	Retinal Disease	☐		
Kidney Disease	☐	High Blood Pressure	☐		

Social History

Smoking Status
☐ Never Smoked
☐ Current, every day
☐ Occasional smoker
☐ Former Smoker

Alcohol ☐ Yes ☐ No
If Yes how much? _____

Illegal Drugs used _____
How Much _____
How Long _____
When Quit _____

By signing below you verify that the information listed is correct and up-to-date

Signature: _____

Date: _____