Clayson Williams
EYE CENTER

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

ACTA DE PRIVACIDAD

De acuerdo con HIPPA, acepto que Clayson Williams Eye Center me ha informado sobre el aviso de Practia de Privacidad.

Nombre del Paciente _____

Firma del Paciente _____

Fecha _____

Lista de aquellos que tienen mi permiso para tener acceso a mi información médica.

Nombre _____ Relacion al Paciente _____

Nombre _____ Relacion al Paciente _____

Nombre _____ Relacion al Paciente _____

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

Información de Paciente

Fecha: _____

Nombre:_____
Apellido Primer Nombre Segundo Nombre

Dirección de Casa_____ Ciudad:_____ Estado: ___ Código Postal:_____

Teléfono de Casa:_____ Número de Celular: _____ Teléfono de Trabajo: _____

Empleador: _____ Fecha de Nacimento: _____ Edad: ____ Numero de Seguro Social: _____-___-____

Sexo: Hombre o Mujer Estado civil: Soltero/a Casado/a Divorciado/a Viudo/a

Idioma: _____ Raza: _____ Etnicidad: _____

Correo electrónico: _____ Farmacia: _____Teléfono: _____

Doctor Familiar: _____ Teléfono: _____

Referido por: _____

Aseguranza/Seguro Primario

Nombre de Aseguranza: _____Numero de ID: _____ Groupo: _____

Tenedor de Poliza: _____ Fecha de Naciemento: _____ Sexo: _____

Dirección: _____Ciudad: _____Estado: ___Código Postal: _____

Relación al Tendedor de Poliza: _____Empledor del Tenededor de Poliza: _____

Segundo Aseguranza/Seguro

Nombre de Aseguranza: _____Numero de ID: _____
Groupo:_____

Tenedor de Poliza: _____ Fecha de Naciemento: _____ Sexo: _____

Dirección: _____ Ciudad: _____Estado: ____ Código Postal: _____

Relación al Tendedor de Poliza: _____ Empledor del Tenededor de Poliza: _____

Pariente más cercano, no viviendo contigo

Nombre: _____ Relación con el Paciente: _____

Dirección: _____Ciudad: _____ Estado: ____ Código Postal: _____

Teléfono de casa: _____ Número de celular: _____ Teléfono de trabajo: _____

Autorización para Tratamiento y Acuerdo Financiero

Yo autorizó tratamiento para la persona llamado como paciente y estoy de acuerdo de pagar por todo los servicios prestados para el paciente incluyendo pero no limitado a cualquier cantidad que no esté pagado departe de mi aseguranza/seguro. Yo estoy responsable por todo los copagos, deducible, coaseguros, cargo de refracción y/o por servicios que no están cubiertos. Autorizo a los representantes de Clayson-Williams, para que proporcionen la información médica pertinente a la aseguradora cuando ésta lo solicite o para facilitar el pago de un reclamo.

Terminos y Condiciones

A todas las cuenta delinquentes se le cobrare interes de 1.5% por mes (18% anual). En el caso de que una cuenta quede sin pagar, está de acuerdo de pagar por todo los costos de colección. En el caso de una demanda para coleccionar una cuenta sin pagar, el abajo firmante además acepta pagar los costos de corte y honorarios razonables de abogado. Usted acepta, para que nosotros podemos coleccionar cualquier cantidad que se quede sin pagar. Nosotros podemos contactarlo por teléfono, con cualquier número de teléfono que esté asociado con su cuenta. Esto incluye el número de teléfono celular, y esto podría resultar en cargos para usted. Nosotros podemos contactarlo con mensaje de texto o correo electrónico, usando cualquier correo electrónico que ustede nos dio. Formas de contacto puede incluir pregrabado voces artificial y/o el uso de un servicio de marcación automática, según corresponda.

Yo/ Nostoros hemos leido esta divulgacion y estamos de acuerdo a los terminos listados arriba.

Firma: _____ Fecha: _____

Nombre con letra clara: _____

Nombre _____

POR FAVOR LLENE TODA LA PÁGINA COMPLETAMENTE

Marque las casilla que Correspondan

Ojos
- Cirujia de los Ojos ☐
- Lentes de Contacto ☐
- Dolor de Ojos ☐
- Visión Doble ☐
- Glaucoma ☐
- Cataratas ☐
- Degeneracion Macular ☐
- Ojos Secos ☐
- Ojos Rojos ☐
- Ardor de Ojos ☐
- Ojos llorosos ☐
- Ojos Cansados ☐

Orejas, Nariz y Garganta.
- Hipoacúsico /Perdida audi ☐
- (Con deficiencias auditivas)
- Vértigo ☐
- Zumbido en el oído ☐

Cardiovascula
- Dolor de Pecho ☐
- Mareo ☐
- Desmayos ☐
- Falta de Aire ☐
- Arritmia ☐
- Dificultad para Acostarse ☐

Constitucional
- Fatiga/Debilidad ☐
- Fiebre ☐
- Pérdida/Aumento de Peso ☐
- Riesgo de Caida ☐

Sistema Respiratorio
- Tos ☐
- Congestión ☐
- Sibilancia ☐
- Asma ☐

Gastroenterología
- Agruras ☐
- Náusea/Vómitos ☐
- Ictericia (aspecto amarillento/Hepatitis) ☐

Genitourinario/a
- Dolor/Dificultad ☐
- Sangre en el Urina ☐
- Historia de cálculos renales (piedra de riñón) ☐
- Enfermedades Transmitidas Sexualmente ☐

Psiquiátrica
- Ansiedad/Depresión ☐
- Cambio en el estado del ánimo o del humor ☐
- Dificultad para Dormir ☐

Endocrino/a
- Sed Excesiva ☐
- Aumento del Apetito ☐
- Micción Frecuente ☐
- Sudoración Excesiva ☐
- Cambios en las Uñas ☐

Sangre/Ganglios linfáticos
- Moretones con facilidad ☐
- Encías que Sangran Facil ☐
- Sangrando excesivo ☐
- Uso intensivo de aspirina ☐

Músculo Esquelético
- Rigidez ☐
- Artritis/Reumas ☐
- Inflamación de articulaciones ☐

Piel
- Sarpullido ☐
- Lesión ☐
- Urticaria/Eczema ☐

Neurológico/a
- Convulsión ☐
- Parálisis ☐
- Entumecimiento ☐
- Temblores ☐

Inmunológico/a
- Ronchas ☐
- Comezón ☐
- Flujo nasal ☐
- Presión en el Seno Nasal ☐
- ¿Has tenido la vacuna contra la influenza?
  Si ☐ No ☐
- ¿Has tenido la vacuna contra la neumonía?
  Si ☐ No ☐

Alergias a medicamentos: _____

Historia Ocular Pasada	**Cirugía Ocular Pasada**	**Medicamento para los Ojos** (de hoy en dia)

VER OTRO LADO

HISTORIAL MÉDICA

Diabetes ☐
Alta presión de la sangre ☐
Enfermedad del Corazón ☐
Enfermedad del Riñon ☐
Cáncer ☐
Si la respuesta es afirmativa, ¿Cual? _____

Cirugía Pasadas ☐

Si la respuesta es afirmativa, ¿Que Tipos?

_____
_____
_____
_____
_____
_____
_____
_____

Medicamentos (de hoy en dia)

Diluyente de la Sangre ☐
Medicamentos para el Diabetes ☐
Otro Medicamentos: ☐
Si la respuesta es afirmativa, por favor liste:

_____
_____
_____
_____
_____
_____

HISTORIA MÉDICA DE LA FAMILIA

Diabetes ☐
Cáncer ☐
Enfermedad del Corazón ☐
Embolia ☐
Tuberculosis ☐
Enfermedad del Riñon ☐

Ceguera ☐
Cataratas ☐
Glaucoma ☐
Degeneracion Macular ☐
Enfermedad de la Retina ☐
Alta presión de la Sangre ☐

Artritis/Reumas ☐
Ojos Bizco ☐
Otro: ☐

_____
_____
_____

HISTORIA SOCIAL

¿Usted Fuma?

☐ Nunca
☐ Todo los dias
☐ Fumador Ocasional
☐ Ex Fumador

Alcohol Si ☐ No ☐

Si la respuesta es afirmativa, ¿Que tanto?

_____

¿Usted usa o e usado drogas ilegales? Si ☐ No ☐

Si la respuesta es afirmativa, ¿Que tanto?

_____

¿Cuánto tiempo? _____

¿Cuando lo dejastes? _____

Por favor firma si la información dada es correcta y completa.

Firma: _____

Fecha: _____

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
(06/2011)	_____
	Date

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.