Lakewood Eye Care

Welcome,

Thank you for choosing Lakewood Eye Care Center, by completing this patient information form you will help us serve you more efficiently. Should you have any questions concerning our professional services or office procedures, please feel free to ask a member of our front office staff.

Patient Information **Date: _____**

Last Name: _____ First Name: _____ Middle: _____
Address: _____City:_____ State: _____ Zip: _____
Email Address: _____ SS#: _____-_____-_____ DL#: _____
Date of Birth: _____ Age: _____ Sex: M / F Occupation: _____
Primary phone: (_____) _____ Secondary Phone: (_____) _____
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
Spouse or Parent's Name: _____ Employer: _____
Person to contact in case of emergency: _____ Phone: _____
Reason for today's visit: _____ Date of last eye exam: ____/____/___
Age of current glasses: _____ Type of glasses: _____
List of medications if any: _____
Email:_____

INSURANCE INFORMATION: ____ No Vision Insurance ____ Discount Plan ____ Claim Form Given
Primary Insurance
Insurance Name: _____ID#:_____ Group ID: _____ Policy Holder:_____
Secondary Insurance
Insurance Name: _____ID#:_____ Group ID: _____ Policy Holder:_____

Please circle any of the medical problems that apply to you or your immediate family

Diabetes	Self	Family	None	**High Blood Pressure**	Self	Family	None
Thyroid Disease	Self	Family	None	**Cardiovascular Disease**	Self	Family	None
Glaucoma	Self	Family	None	**Respiratory Problems**	Self	Family	None
Lazy Eye	Self	Family	None	**Retinal Detachment**	Self	Family	None
Cataracts	Self	Family	None	**Head/ Eye Injury**	Self	Family	None
Double Vision	Self	Family	None	**Macular Degeneration**	Self	Family	None
Cancer	Self	Family	None	**Headaches/ Migraines**	Self	Family	None
Major Surgeries	Self	Family	None	**Lasik (Refractive) Surgery**	Self	Family	None

Acknowledgement of the Federal HIPPA Privacy Practices
I acknowledge that I have received and/or reviewed a copy of the HIPPA Privacy Practices.
Signature: _____ Date: _____

Patient Signature: _____ **Date**: ____/____/_____

Financial Policy

Lakewood Eye Care

Thank you for choosing Lakewood Eye Care. We are committed to providing you and your family with the best available medical care. In our ongoing process to make sure that all your medical needs are met, our billing department is available to discuss our fees and this policy with you.
We ask that all responsible parties read and sign our financial policy as well as complete the patient information forms prior to seeing the physician.
Payment for all services will due at the time services are rendered. In order to serve you better we accept cash, check Visa, MasterCard and Discover.
As the responsible party, please understand (please initial by the following):
_____ 1. Your insurance policy is a contract between you, your employer and the insurance company. We are not a party to that contact. Our relationship is with you, not your insurance company. We will not become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurance and "usual customary" charges. As your medical provider, we will only supply factual information to facilitate claim processing.
_____ 2. Fees for services, which include unpaid balances, deductibles, and co-payments, are due at the time of services. Return checks and unpaid balances may be subject to collection placements and collection fees of **$25.00**.
_____ 3. All charges are your responsibility, whether you're insurance company pays or does not pay. If your insurance carrier does not remit payment within sixty days, the balance will be due in full from you. If any payment is made directly to you for services billed by Lakewood Eye Care, you recognize an obligation to promptly remit payment to Lakewood Eye Center.
_____ 4. We will only file the first two insurances; if you have more than two you will be responsible to file the rest.
_____ 5. All Medicare and Medicare Advantage patients will be responsible for the refractive charge of the exam. Medicare does not cover any procedure that is routine. If your Sup will cover it you are responsible for filing it.
_____ 6. Forms/Letters- We will be happy to complete forms and write medical letters for you upon your request. The fee of this service varies depending on the forms are **$25.00 per form**, and the payment is collected when you pick up the form(s). Please allow 10 business days for us to complete the form. Medical letters printed on company letterhead are **$10.00 per letter** and payment is also collected when you receive the letter.
_____7. Medical Records – Please remember that payment is due at the time of service. For your convenience, we accept cash, checks, MasterCard, Visa, and Debit Cards. There is a **$25.00** fee assessed for returned checks. In the event that your account becomes past due, and all efforts to collect payment have failed, your account may be referred to a collection agency.
_____8. Third Party Liability – We do not file insurance claims for third-party accidents, (i.e. motor vehicle insurance or property insurance). You will be asked to make full payment at the time of service, and you will need to file the claim with the insurance company.

Patient Signature: _____ **Date**: ____/____/_____