

WELCOME TO OUR OFFICE

PATIENT INFORMATION

HOW DID YOU FIRST HEAR ABOUT OUR OFFICE? _____

PLEASE CHECK ONE: () DR () MR () MRS () MISS () MS () _____

FULL LEGAL NAME _____ PREFERRED 1ST NAME _____

ADDRESS _____ CITY _____ STATE ____ ZIP CODE _____

DATE OF BIRTH _____ AGE _____ SOCIAL SECURITY NUMBER _____

HOME PHONE: () _____ CELL PHONE: () _____ DRIVERS LICENSE NO: _____

ARE YOU () MINOR () MARRIED () DIVORCED () WIDOWED () SINGLE () SEPARATED

NAME OF EMPLOYER _____ OCCUPATION _____

EMPLOYER ADDRESS _____ WORK PHONE () _____

SPOUSE'S NAME _____ DATE OF BIRTH _____ SSN _____

SPOUSE'S EMPLOYER _____ OCCUPATION _____

EMPLOYER ADDRESS _____ WORK PHONE () _____

RESPONSIBLE PARTY (IF SOMEONE OTHER THAN PATIENT)

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____

RELATIONSHIP TO PATIENT _____ HOME PHONE () _____

ADDRESS _____ CITY _____ STATE ____ ZIP CODE _____

DATE OF BIRTH _____ SOCIAL SECURITY NUMBER _____

NAME OF EMPLOYER _____ WORK PHONE () _____

EMPLOYER ADDRESS _____ CITY _____ STATE ____ ZIP CODE _____

INSURANCE INFORMATION (PLEASE HAVE CARD AVAILABLE FOR COPYING)

DO YOU HAVE VISION INSURANCE? () YES () NO

NAME OF INSURANCE COMPANY _____

NAME OF INSURED _____ POLICY NUMBER: _____

DO YOU HAVE HEALTH INSURANCE? () YES () NO

NAME OF INSURANCE COMPANY _____

NAME OF INSURED _____ POLICY NUMBER: _____

AUTHORIZATION

PLEASE READ THE FOLLOWING CAREFULLY AND INITIAL WHERE INDICATED!

I AUTHORIZE: THE RELEASE OF ANY INFORMATION NECESSARY TO DETERMINE LIABILITY FOR PAYMENT AND TO OBTAIN REIMBURSEMENT ON ANY CLAIM; THE PAYMENT OF BENEFITS TO WHICH I AM ENTITLED TO BE MADE DIRECT TO DR. LOTZ; THIS ASSIGNMENT TO REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING; A PHOTOCOPY OF THIS ASSIGNMENT TO BE CONSIDERED AS VALID AS AN ORIGINAL.

_____ **I UNDERSTAND:**

- initials
- 1) THAT INSURANCE IS CONSIDERED A METHOD OF REIMBURSING THE PATIENT FOR FEES PAID TO THE DOCTOR AND IS NOT A SUBSTITUTE FOR PAYMENT;
 - 2) THAT SOME COMPANIES PAY FIXED ALLOWANCES FOR CERTAIN PROCEDURES AND OTHERS PAY A PERCENTAGE OF THE CHARGE

_____ **I UNDERSTAND:**

- initials
- 1) THAT I AM ULTIMATELY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT THEY ARE PAID BY MY INSURANCE;
 - 2) THAT IT IS MY RESPONSIBILITY TO PAY ANY DEDUCTIBLE AMOUNT, CO-INSURANCE OR ANY OTHER BALANCE NOT PAID FOR BY MY INSURANCE.

_____ **I FURTHER UNDERSTAND:**

- initials
- 1) THAT A 2% MONTHLY FINANCE CHARGE WILL BE ADDED TO ALL BALANCES THAT ARE THIRTY (30) DAYS PAST DUE OR GREATER;
 - 2) THAT IF THIS ACCOUNT IS ASSIGNED TO AN ATTORNEY OR AGENCY FOR COLLECTION AND/OR SUIT, THE PRACTICE SHALL BE ENTITLED TO REASONABLE ATTORNEY'S FEES AND COSTS OF COLLECTION;
 - 3) THAT THERE WILL BE A \$20.00 CHARGE FOR ALL RETURNED CHECKS.

IN ORDER TO CONTROL THE HIGH COST OF BILLING, WE REQUEST THAT CHARGES FOR OFFICE VISITS BE PAID AT THE CONCLUSION OF EACH VISIT.

SIGNATURE: _____ **DATE:** _____

ci _____

pc _____