

Please complete ALL blanks – Place "N/A" (Not Applicable) if information does not apply. **It is imperative that the information is thorough and accurate as the information is utilized for claims processing.**

Patient's Information:

Name:	Sex (circle one): M F	Marital Status:
SS#: - -	DOB: / /	Patient's Primary Phone #: () -
St. Address:	Patient's Work Phone #: () -	
City: State: Zip:	Patient's Alternate Phone #: () -	
Emergency Contact:	Family Doctor OR Referring Doctor.:	
Emer. Contact Phone #: () -	Ref. Dr. Phone #: () -	
E-Mail Address: _____		
Pharmacy Name and Location: _____		

Patient's Primary Insurance Information: (The subscriber is the *person* who carries the insurance)

Ins. Co. Name:	ID #:	Grp./Acct. #:
Subscriber (circle one): Self Other ***** ONLY If "Other," need to complete info. below		
Subscr. Name:	Subscr. SS#: - -	Subscr. DOB: / /
Subscr. St. Address:	Subscr. Sex: M F Relationship to patient:	
City: State: Zip:	Subscr. Home Phone #: () -	

Patient's Secondary Insurance Information: (The subscriber is the *person* who carries the insurance)

Ins. Co. Name:	ID #:	Grp./Acct. #:
Subscriber (circle one): Self Other ***** ONLY If "Other," need to complete info. below		
Subscr. Name:	Subscr. SS#: - -	Subscr. DOB: / /
Subscr. St. Address:	Subscr. Sex: M F Relationship to patient:	
City: State: Zip:	Subscr. Home Phone #: () -	

Patient's Additional and/or Routine Vision Insurance Information:

Ins. Co. Name:	ID #:	Grp./Acct. #:
Subscriber (circle one): Self Other ***** ONLY If "Other," need to complete info. below		
Subscr. Name:	Subscr. SS#: - -	Subscr. DOB: / /
Subscr. St. Address:	Subscr. Sex: M F Relationship to patient:	
City: State: Zip:	Subscr. Home Phone #: () -	

Patient's Employment Information:

Employer Name:	Employer Phone #: () -
Employer St. Address:	City: State: Zip:

***** If this visit is work or auto-accident related, please advise the receptionist. *****

Guarantor Information: (Only need to complete if the patient is under the age of 18)

Guar. Name:	Guar. SS#: - -	Guar. DOB: / /
Guar. St. Address:	Guar. Sex: M F Relationship to patient:	
City: State: Zip:	Guar. Home Phone #: () -	

My signature on this page signifies that all the above information is current and accurate. I understand that I will be called by my name at the time I am asked to proceed to the examination room.

*******PATIENT'S SIGNATURE OR Guarantor or Personal Representative's Signature** _____ **Date** _____

FINANCIAL AGREEMENT

Thank you for choosing Douglas J. Lavenburg, MD, PA for your family eye care needs. We are pleased to welcome you to our practice. Our chief concern is that you and your family receive the finest care for maintaining healthy vision.

We understand that occasionally some of our patients will experience financial difficulties. It is our hope that you will bring these situations to the attention of our billing department or office manager to allow us to help you manage your account in the most effective manner. Please be advised that your insurance company is a contract with you and your employer. We will be glad to submit your claims for payment; however, the final responsibility for payment due for services rendered is the sole liability of you, the patient or the guarantor.

Our financial policy is as follows. Please feel free to discuss this with our billing department at any time. Please complete all insurance information, read our financial policy, and sign below to verify the receipt of this information.

1. We accept cash, check, Visa, MasterCard or Care Credit. We are sorry, but we do not accept Discover or American Express.
2. Medicare and some other insurance carriers do not pay for your refraction. A fee of \$25.00 is due at the time of your visit.
3. If Medicare is your primary insurance, and your visit is for a medical condition, we will gladly submit your insurance claim to Medicare for you. You will be responsible for any co-insurance and/or deductible.
4. Your co-payment and self payment amounts are due at the time of service.
5. You are financially responsible for all payments not paid by your insurance company.
6. If we do not participate with your insurance carrier, payment is due at the time of service.
7. If your insurance carrier requires a referral from your primary care provider for treatment, it is your responsibility to obtain the referral prior to your appointment. If you do not obtain and provide the referral within the time allowed by your insurance carrier, you will be financially responsible for services rendered.
8. Returned checks are subject to a \$25.00 service charge.
9. It is your responsibility to advise our office if you are being seen as part of a Vision Benefit Package provided by your employer prior to your appointment.
10. We are happy to provide any counseling on our billing practices; however, if your account is not paid within 60 days you will be responsible for payment plus a monthly finance charge of 1.5% per month.
11. If we are participating with your insurance company, we are contracted to "adjust" your account by a certain amount which is known as a "contractual write-off." This does not mean you will not have a balance. We will bill you for monies as directed by your insurance company.
12. If your account goes into "collections," in addition to your outstanding balance, you will be responsible to pay a 33% fee charged by the collection agency as well as any legal or court costs as specified by our collection agency.
13. Any Medical Necessity forms/letters required by your insurance company, or any communication outside the usual and customary forms required for billing or communication with other physician providers, will be subject to a \$25.00 administrative fee.
14. We will be happy to complete your disability forms which are subject to a \$25.00 administrative fee.
15. As a courtesy to our patients relocating out of the area, we will be happy to supply your new eye care provider a copy of your medical records at no charge. Any other requests for copies of medical records will be subject to a \$5.00 (\$10.00 if there are colored photos) administrative fee.
16. You will have 90 days to return for a recheck of your glasses prescription for a fee of \$25.00. There will be a courtesy waiver of this fee for glasses purchased at our optical locations. After 90 days, a \$45.00 refraction fee will be charged.
17. **As a courtesy to our patients, we require a 24 hour notice of cancellation of your appointment. Anything other will be subject to a \$50.00 missed appointment fee.**

Your signature on this page signifies that you acknowledge and accept the above information. This also serves as an assignment of insurance benefits to be paid directly to Douglas J. Lavenburg, MD, PA.

Douglas J. Lavenburg, MD, PA.

✓

Patient, Guarantor or Personal Representative's Signature

Date

NOTICE OF PRIVACY PRACTICES --- SUMMARY AND ACKNOWLEDGEMENT

We will use and disclose your health information in order to:

1. Treat you or to assist other health care providers in treating you
2. Obtain payment for our services and to allow insurance companies process claims for services rendered to you
3. Comply with quality assessments and licensing requirements

Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization. However, in the following circumstances, we may disclose your health information without your written authorization:

- To family members or care takers who are involved in your health care
- For purposes of public health and safety
- To government agencies and health insurance companies for purposes of their audits, investigations, and other oversight activities
- To government authorities to prevent child abuse of domestic violence
- To the FDA to report product defects or incidents
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders
- When required by court orders, search warrants, subpoenas, and as otherwise required by law

This information may be submitted by the following methods: U. S. Postal Service and similar delivery services, facsimile, Internet, voice mail, telephone, and/or personal communications.

The most common types of entities to whom we typically provide personal health-related information are: physicians outside of this practice, medical facilities (i.e. hospitals, nursing homes), laboratories for medical tests, pharmacies, insurance companies, state and federal agencies.

Occasionally, we may mail patient forms and surgery information to you. Additionally, we will mail account statements to you. We may need to contact you by telephone to confirm or change appointments, discuss treatment, ask about referrals or discuss account balances. If we cannot reach you at home and need to call you at work, we will only leave a message for you to return our call. So we can ensure that this information gets directly to you, please be sure to inform us of any address or telephone number changes.

PATIENT RIGHTS:

- To have access to and/or a copy of your health information
- To receive an accounting of certain disclosures we have made of your health information
- To request restrictions as to how your health information is used or disclosed
- To request that we communicate with you in confidence
- To request that we amend your health information
- To receive notice of our privacy practices

If you have a question, concern, or complaint regarding our privacy practices or you wish to have more information, please request a copy of the Notice of Privacy Practices.

If you would like copies of your medical records and/or information sent to another physician, medical facility, your life insurance carrier, disability insurer, or other entity, you must authorize the release of this information in writing. We can provide you with the necessary form.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

I acknowledge that I was provided a copy of the Notice of Privacy Practices Summary and was offered a complete copy of the Notice of Privacy Practices.

Patient Name (Please print)

Signature

Date

Parent or Authorized Representative (if applicable)

Date

OFFICE USE ONLY: In lieu of patient signature, I, _____ state the above has been provided on _____.

Informed Consent for the Fitting of Contact Lenses

The major use of contact lenses is for the correction of refractive errors. A small number of patients who meet pre-fitting criteria are unable to tolerate contact lenses regardless of fitting technique or lens type. It is important to remember that contact lenses are medical devices used to correct vision, and when used improperly, can cause permanent visual loss, especially when sleeping in them. Complications may arise with the use of contact lenses; the changes usually occur to the cornea and eyelids. Even a patient that has tolerated contacts for years may develop problems. For these reasons, yearly eye examinations are essential. **We also require all new contact lens patients, or patients new to our practice, to have a contact lens fit and evaluation, which includes a one week follow-up visit. If follow-up visits are not kept, we will NOT be able to order lenses or release the contact lens prescription.**

Financial Responsibility for Contact Lens Services

New Contact Lens Wearers:

The glasses prescription is **not** the same as the contact lens prescription. All new contact lens wearers need to schedule a contact lens fit. The price typically ranges from \$90 (single vision) to \$130 for more complicated fits (soft bifocal / multivision). This fitting fee is non-refundable. The fit includes an initial evaluation, a contact lens training session, and a one week contact lens evaluation (follow-up). We provide a 30 day warranty on our services pertaining to the proper fitting of contact lenses. If the contact lens evaluation (follow-up) is not completed within 30 days, an additional charge of \$25.00 will be incurred.

Established Contact Lens Wearers:

If a change in fit or lens type is required, a contact lens refit evaluation will be performed. The price typically ranges from \$80 for single vision and up to \$130 for bifocal refits. This refit service includes the contact lens refit evaluation and a one week contact lens evaluation (follow-up) with the newer lenses.

However, if the current lenses are satisfactory with the patient and the doctor, only a contact lens evaluation fee of \$55 will be charged to existing patients and \$75.00 will be charged to patients new to our practice.

Contact Lens Ordering and Reordering Policy:

It is recommended that all patients being fit/refit for contacts purchase their first order from the practice.

Payment in full is required for all contact lens orders.

A fee of \$20 is applied to all cancelled orders, as well as a 20% restocking fee.

In the event that it is necessary to return or exchange contact lenses, unopened and boxes not written on may be returned within 30 days.

I have read, understand, and agree with the Informed Consent and Financial Responsibilities for contact lens services.

Please sign below, OR indicate "N/A" (Not Applicable) on the signature line if contact lens services are not being received.

✓

Patient, Guarantor or Personal Representative's Signature

Date

Name: _____

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(Check one): _____ Existing Patient _____ New Patient

We are happy that you have chosen our office for your eye and skin care. We thank you for taking a moment to complete the following so we can better serve you.

Would you be interested in learning more about any of the following? Please check all that apply.

- | | |
|--|--|
| <input type="checkbox"/> Refractive Surgery (Lasik, Lens implants) | <input type="checkbox"/> Botox |
| <input type="checkbox"/> Cosmetic Eyelid Surgery | <input type="checkbox"/> Cosmetic Fillers |
| <input type="checkbox"/> Hair Removal | <input type="checkbox"/> Skincare Treatments |
| <input type="checkbox"/> Glasses | <input type="checkbox"/> Contact Lenses |
| <input type="checkbox"/> High Definition Lenses | <input type="checkbox"/> Bifocals |
| <input type="checkbox"/> Prescription Sunglasses | <input type="checkbox"/> Fashion Sunglasses |

Is there anything that you dislike about your current eyewear?

How many hours a day do you use a computer? _____

Do you experience problems with glare? ___yes ___ no

I have worn contact lenses/glasses? ___currently ___ in the past ___ never

I have been told that I was not a candidate for contact lenses. ___yes ___ no

Why? _____

I participate in the following activities:

- | | |
|--|--|
| <input type="checkbox"/> Reading | <input type="checkbox"/> Sports (what kind?) _____ |
| <input type="checkbox"/> Needlework/Sewing | <input type="checkbox"/> Boating |

How did you hear about us? Please check all that apply.

- | | |
|---|--|
| <input type="checkbox"/> Friend/family member. Who may we thank _____ | |
| <input type="checkbox"/> Doctor _____ | <input type="checkbox"/> Yellow Pages: (circle) <u>Verizon</u> / <u>Yellowbook</u> |
| <input type="checkbox"/> Our website/internet | <input type="checkbox"/> Radio (which station?) _____ |
| <input type="checkbox"/> Direct mail | <input type="checkbox"/> Health Fair/Show (which?) _____ |
| <input type="checkbox"/> Newspaper (which?) _____ | |