

LIPSTOCK

LASIK & CATARACT CENTER

Kenneth D. Lipstock, M.D.

Legal Name: _____
First M.I. Last "nickname"

Address: _____
Street City State Zip

DOB: _____ Age: _____ SSN #: _____ - _____ - _____

Home #: _____ Work #: _____ Cell #: _____

Email: _____

Employer: _____

Occupation: _____ Marital Status: _____

Primary Care Physician: _____ Phone #: _____

Emergency Contact Name: _____ Phone #: _____

Were you referred by another Physician? If yes, whom? _____

How did you hear about us? _____

Thank you for choosing Lipstock LASIK & Cataract Center for your eye care needs. We will be happy to file your insurance claim if we participate with your insurance company. If your insurance requires a referral it is **your** responsibility to provide us with the referral before services are rendered or the visit will be self pay, due at the time of service. All co payments must be paid at the time of your visit. WE NO LONGER BILL FOR COPAYMENTS. If your insurance does not cover all or part of the services rendered you will be responsible for the balance due.

Keeping your appointment is vital in ensuring the health of your eyes. In an effort to continuously provide prompt and efficient healthcare; we require 24 hours notice for canceled appointments. Otherwise, \$25 will be billed to your account.

I authorize the release of my information including but not limited to any diagnosis and/or records of my treatment or exams to insurance companies and/or health practitioners. I authorize my insurance company to pay benefits directly to Dr. Kenneth Lipstock. If my account is referred to an attorney for collection, upon said referral I agree to pay attorney's fees in the amount of thirty three and one third percent of the total outstanding debt (which includes but is not limited to, principle, accrued interest and late charges) then due and all costs of collection. I agree to pay the aforesaid attorney's fees and costs of collection whether or not the attorney files suit. A photocopy of this contract shall be considered as valid as the original. I certify that I have read and understand the above information.

Patient Signature (or legal guardian if patient is under the age of 18)

Date