

# LIPSTOCK

## LASIK & CATARACT CENTER

Legal Name: \_\_\_\_\_  
*First M.I. Last "nickname"*

Address: \_\_\_\_\_  
*Street City State Zip*

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ M / F SSN #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Work #: \_\_\_\_\_ Email: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Retired Y / N Retired from? \_\_\_\_\_ Marital Status: \_\_\_\_\_

When was your last eye exam? \_\_\_\_\_ By whom? \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

I agree to pay for all services rendered to me by Lipstock Lasik & Cataract Center. I understand that as a courtesy to its patients providing insurance/billing information, Lipstock Lasik & Cataract Center will submit claims to my health care plan or insurance company. However, further I understand that I am responsible for payment of the balance owed. I agree that I am also responsible for any deductibles, co-payments, co-insurance or charges for non-covered services, charges for services not deemed "medically necessary" or charges for which I have not obtained a properly authorized written referral, or authorization if required by my health plan. In the event that I am not currently enrolled as a member of a health care plan, I am personally responsible for all charges incurred for services. I understand that all co-payments are due at the time of service.

I authorize my insurance company to pay benefits directly to Dr. Kenneth Lipstock and/or Lipstock Lasik and Cataract Center. I understand Lipstock Lasik & Cataract Center participates with most health and/or vision insurance companies, and if I have a medical eye condition such as glaucoma, cataracts, dry eyes, allergic conjunctivitis or macular degeneration my medical insurance will be billed. If my eyes are healthy, whether or not I need eyeglasses, my exam will be filed under my vision insurance.

I authorize the release of my information including but not limited to any diagnosis, photos, videos and /or records of my treatment or exams to insurance companies and/or health practitioners. I authorize Lipstock Lasik & Cataract center to disclose all or part of my medical record to any insurance carrier, person or corporation which is or may be liable under contract to Lipstock Lasik & Cataract Center or to me or to a family member of mine for all or part of Lipstock Lasik & Cataract Center charges. This authorization includes, but is not limited to workers compensation carriers, Anthem (Blue Cross/Blue Shield), commercial insurance carriers, and the fiscal intermediary under Medicare and Medicaid. I hereby give my permission to the staff of Lipstock Lasik & Cataract Center to carry out all necessary diagnostic, assessment and treatment activities which address the needs of the patient named above.

**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 hour notice for canceled appointments. Otherwise, a fee of \$25 for non-dilated appointments or a fee of \$50 for dilated appointments will be billed to your account.**

*If my account is referred to a collection agency or attorney, upon said referral I agree to pay the collection agency/ attorney's fees in the amount of thirty three 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.*

*I agree to the terms listed above*

*Date*