LIPSTOCK
LASIK & CATARACT CENTER

Kenneth D. Lipstock, M.D.

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

Address: _____
Street *City* *State* *Zip*

DOB: _____ **Age**: _____ **M / F** **SSN #:** _____ - _____ - _____

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

Email: _____ **Marital Status:** _____

Occupation: _____**Employer:** _____

Retired Y / N **Retired from?** _____

When was your last eye exam? _____ **By whom?** _____

Primary Care Physician: _____ **Phone #:** _____

Emergency Contact Name: _____ **Phone #:** _____

How did you hear about us? _____

Health insurance generally does not cover the cost of Laser Vision Correction. That is why we require payment by the patient at the time of their procedure. However, some insurance carriers have begun to offer reimbursements/discounts for Laser Vision Correction as an added benefit to the plan and not as a covered procedure. It is the responsibility of the patient to investigate potential insurance reimbursements/discounts for Laser Vision Correction procedures prior to scheduling the procedure with us. Patients are responsible for making full payment for Laser Vision Correction no later than the day of their procedure. If there are avenues for reimbursements/discounts through the patient's insurance company it is the responsibility of the patient to submit a receipt for services to the insurance carrier for direct reimbursement after their Laser Vision Correction procedure. Lipstock LASIK & Cataract Center will not submit a claim form for these reimbursements/discounts since Laser Vision Correction is not a "covered" procedure.

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 $50 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, principal 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*