Welcome to Lifetime Eye Care

Patient Information

Legal Name: ________________________________
First MI Last

Nickname: (Please call me): ______________________

Circle one: I am: Dr Mr Mrs Ms Miss Jr Sr I II III

Circle one: I am: Married Single Widow Domestic Partner

Circle one of the following that applies to the patient:
I am employed: Full-Time Part-Time Self-Employed Retired
Homemaker Currently not employed
If Student **Circle one**: Full-Time Student Part-Time Student

Address: ________________________________
City: ____________________ State: _____ Zip: ______
Date of Birth: ____/____/____ Age: ________ Sex: M or F

Social Security Number: _______/_______/_________

Home Phone: (_______)_________-____________
Work Phone: (_______)_________-____________
Cell Phone: (_______)_________-____________

Employer: ________________________________
Occupation: ______________________________

Your Email is only used for in-office professional purposes only, such as; recall, confirming appointments & for our contact lens patients, passwords for ordering contact lenses on online. *It will never be shared with any outside persons or sources*.
Home Email: ______________________________
Alternate Email:

For New Patients: Whom may we thank for referring you?

Acknowledgment of Notice of Privacy Practices (NPP)

The Federal Law requires that we make every effort to inform you, the patient, of your right related to your personal health information.
Please initial only one below

___ **Yes**, I **have** read or had explained to me by this office the NPP & I wish to continue my care with Lifetime Eye Care/Jeffrey E Schultz, OD, Inc under said terms.

___ **No**, I **have not** read this office's NPP but, I was given the opportunity to read it upfront and declined. I wish to continue my care with Lifetime Eye Care/Jeffrey E Schultz, OD, Inc. under said terms.

___ The NPP **could not be read** due to the emergent nature of the care or other reasons described below.
Comments: ____

Health Information Release to Family, Friends, Others

Please initial only one below

_____ **Yes, I authorize** all persons listed below the ability to receive materials in my absence or information on my behalf

Name: ______________________Relationship________Date_______
Name: ______________________Relationship________Date_______

_____ **No, I Do Not authorize** any persons the ability to receive materials or information on my behalf. I choose to come myself.

Spouse or Parent Information (If applicable)

Name: ____________________________________
First MI Last

DOB: ____/____/____
Employed: Full-Time Part-Time Self-Employed Retired
Homemaker Currently not employed

Employer: ________________________________

Occupation: ______________________________

Work Phone: (_______)_______-_________Ext_______

Medical/Health Insurance Card Information

This office is a medical facility. Your medical insurance may often cover advanced testing and treatment of the eyes. Diseases of the body can show up in the eyes. If the doctor determines the need for additional medical testing or treatment, the following information will help us file your claim.

Employee Name: ___________________________
Date of Birth: ____/___/____ Age: ________ Sex: M or F
Relationship to Patient: Spouse Child F/T Student Other_________

Employer: ________________________________

Occupation: ______________________________

Social Security Number: _______/_______/_________
Drivers License # __________ State _____Exp_______

Medical Plan Name:________________________________
Insured's ID# ____________________ Group#______________

Vision Plan Name_________________________________
Insured's ID# ____________________ Group#______________

Financial Assignment & Release

(Signature Required)

* I, the undersigned, assign directly to Lifetime Eye Care/Jeffrey E Schultz, OD, Inc all insurance benefits, if any, otherwise payable by me or to me for services rendered.
* I understand that I am financially responsible today for all fees. I also agree that I am financially responsible to reimburse any and all fees for services and materials not collected in full at the date of service or should my insurance or vision plan deny payment for services or materials rendered.
* I further understand that after 60 days from the date my services or claim is filed I agree to pay for any unpaid balances on my account as a result of denial in part or whole from my insurance carrier caused by; unmet deductibles, non covered materials or professional services, my negligence in fulfilling any paperwork, providing any required information requested of me by my insurance carrier or uncollected fees on service day.
* Any services recommended or provided by this office may not be covered under the terms of your benefit plan. Eligibility and coverage are subject to the specific terms and conditions of your benefit plan.
* If I fail to reimburse said fees in a timely manner with the above stated office and should the need arise, I agree to pay any and all collection fees, court costs and attorney fees.
* If you do not inform us you have a vision plan or medical insurance before services are rendered, we will assume no coverage exists.
* I agree I am responsible for filing my own claim if I discover I have vision or medical benefits after services or products are rendered.
* I agree this office with NO EXCEPTIONS will not back file claims, post authorize claims, or refund fees after services are rendered due to lack of my notification of vision or medical benefits.

X_____________________________ __/____/____
Patient or Responsible Party Signature Date