WELCOME TO OUR OFFICE

COMPREHENSIVE
EYE CARE
Renée Lobert, O.D.

Optometrists
2700 Five Mile Road NE Ste. 102
Grand Rapids, MI 49525
t. 616.361.6612
f. 616.361.6690
www.drreneelobert.com

PATIENT INFORMATION:

Patient's Name _____

Billing Name _____

Street Address _____

City _____ State____ Zip _____

Date of Birth _____M ❒ F ❒

Single ❒ Married ❒ Other ❒

Occupation _____

Employer_____

How did you choose our office? _____

_____

ACTIVITIES:

Special Occupational Visual Needs _____

_____

_____

_____

Hobbies_____

_____

Sports _____

_____

INSURANCE:

Vision Insurance _____

Subscriber Name _____

Date of Birth _____ ID No. _____

Primary Health Insurance_____

Subscriber Name _____

Date of Birth _____ ID No. _____

Secondary Insurance _____

Subscriber Name _____

Date of Birth _____ ID No. _____

PHONE NUMBERS:

Preferred Primary _____

Home ❒ Work ❒ Cell ❒

Secondary_____

Home ❒ Work ❒ Cell ❒

Emergency Contact Name _____

Contact's Daytime Phone_____

I authorize the release of information regarding my care to:

Name_____ Relationship _____

I authorize the release of any medical information necessary to provide the most beneficial and complete eye examination. Information regarding my care, including scheduled appointments and filled orders:

1. May be left as a message on an answering machine or to an individual who answers the phone. Yes ❒ No ❒
2. May be given only to myself. Yes ❒ No ❒

Signature of responsible party _____ Date _____

PATIENT SERVICE AGREEMENT

OUR COMMITMENT TO YOU:

• Personalized Eye Health Care
• Patient Education
• Exceptional Service with Accuracy
• Controlling Costs

Thank you for choosing us as your eye health care provider. Prior to receiving care, please read and sign the following:

PAYMENT:

- Full payment is due at time of service.
- A minimum of half down is required at time of order with full payment when glasses and/or contact lenses are picked up
- We accept cash, check, credit cards.

INSURANCE:

- Your insurance is a contract between you and your insurance company. We are not a party to that contract. We will pre-certify your coverage at the time of your visit. During pre-certification, every insurance company states, "This is not a guarantee of benefits".
- As a courtesy,we may accept assignment of insurance benefits and we will file your insurance claim for you. Be aware that some, perhaps all, of the services provided may be deemed non-covered services by your insurance company.
- If your insurance requires you to have a prior-authorization or referral, it is your responsibility to request and obtain the needed information. If you do not have one, treatment may be denied.
- The maximum we will wait for insurance reimbursement is 90 days, after which the insurance amount is then payable by you.
- Regarding insurance plans in which we are participating providers, all co-pays and deductibles are due the day service is provided, per your insurance company. You may lose privileges if you do not comply. If we are non-participating providers you are responsible for the balance.

USUAL AND CUSTOMARY RATES:

- You are responsible for payment regardless of your insurance company's arbitrary determination of usual and customary fees.

MINOR PATIENTS:

- The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment may be denied unless charges have been pre-authorized. It is not possible for us to do split billing between accounts.

INTEREST:

- We reserve the right to charge a late fee in the amount of 1% as provided by state law for any unpaid patient balance remaining after 60 days of service.
- Collection proceedings will begin on any outstanding balance in non-compliance with this policy.

Signature of Responsible Party _____Date_____

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