WELCOME TO OUR OFFICE

Patient's Name _____
(Last) (First) (Middle)

Date of Birth____/____/____ Age_____ S.S. #_____-____-_____

Mailing Address_____
(Street)

_____ Martial status (S M D W)
(City) (State) (Zip)

Home Telephone # (___)_____-_____ Alternate Phone # (___)_____-_____
circle (work or mobile #)

Employer/School_____

Job Description/Grade_____

How did you find out about our office? _____

Spouse or Parent Information

Name_____Relationship_____D.O.B_____

Employer_____ Contact Phone Number (___) ____-_____

S.S. # of parent or legal guardian_____-____-_____ (needed only if patient is below the age of 18)

Additional Information

If you have any insurance that applies to your visit today, we will file it one time. By signing below, you authorize assignment of benefits and release of all necessary information for us to file your claim. If your insurance company denies your claim, we will consider any balance due your responsibility. If any portion of the bill is not paid in a timely manner, it will be submitted to our collection attorney and will acquire an additional 35% added to the balance and/or all costs of collecting the balance will be added to the total amount due including court costs and attorney fees. This acknowledgement will remain in your file and applies to all services rendered on and after the date listed below. We at Lantman Eye Care value your privacy. If you would like to receive a written noticeof our privacy practices, please let us know.

Signature of patient or responsible party_____

Date signed_____/_____/_____e-mail address _____

We are participating providers for all the following insurance companies. We will gladly file your insurance one time for these companies. Your current/correct insurance card(s) needs to be presented on the day-of-service if not before. If denied, it will be the patient's responsibility. If you do not know your insurance or vision insurance on the day of service, you will receive a paid receipt to file your own claim.

CIGNA or CIGNA VISION
(Dr. Lantman is an out-of-network provider for medical.
Some plans have an out-of-network vision exam or VSP. We will verify each plan.)
BLUE CROSS BLUE SHIELD PPO
(Non-provider for Network S)
EYEMED (ACCESS PLAN ONLY**)**
MEDICARE
PRIVATE HEALTHCARE SYSTEMS
UNITED HEALTHCARE
(We will verify each individual plan) (Non-provider for UHC River Valley)
VISION CARE PLAN (VCP)
VISION SERVICE PLAN (VSP)

VERIFICATION OF BENEFITS DOES NOT GUARANTEE PAYMENT. PAYMENT IS PATIENTS RESPONSIBILTY IF CLAIM IS DENIED.

**We will gladly check on each plan not listed above to verify in-network benefits. If Dr. Lantman is out-of-network,
you will be given all the proper paperwork needed so that you may file your insurance and be reimbursed if that option is available.**

***Primary/Secondary Insurance:_____**
***Vision Insurance:_____**

Or circle: *No Insurance

(There will be a fee for any returned or unwanted merchandise)

SIGN:_____DATE:_____