Lanter Eyecare and Laser Surgery

PATIENT & INSURED'S INFORMATION (Please be sure every space is filled out. If it does not pertain to you, write N/A)

Patient's Legal Name (Last, First, Middle Initial) **Nick Name**	**Insured's Name ____Patient ____Spouse ____Parent ____Legal Guardian (Please check one)**
Home Address (Street, Apt #)	**Home Address (Street, Apt #)**
City, State & Zip	**City, State & Zip**
Date of Birth **Social Security #**	**Date of Birth** **Social Security #**
Primary Phone # **Secondary Phone #** **Work #**	**Primary Phone #** **Secondary Phone #** **Work #**
Marital Status ____Married ____Single ____Divorced ____Widowed (Check your current status) **Sex: ____Male ____Female**	**Guarantor's Employer & Address**
Patient's Employer	**Patient's Pharmacy Name**
Employer's Address	**Patient's Pharmacy Address**
Primary Care Physician's Name **Office Phone #**	**Patient's Pharmacy Phone #**
Guardian or Emergency Contact **Relationship to patient** **Primary Phone #**	
Email Address **May we contact you? ____yes ____no (We comply fully with Indiana Code 884 IAC 5-3-5)**	**Referred by** **Relationship to patient**

1. I hereby consent to the physician and other persons acting under his direction and supervision to administer examination, treatments, and other procedures as are deemed necessary.

2. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. In addition, I hereby designate **Lanter Eyecare and Laser Surgery** and its employees and agents as my representative to file grievances and to represent me in accordance with the Indiana Code, Title 27, and Chapters 8 & 13. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand this authorization will remain in effect until revoked in writing. I hereby agree to pay **Lanter Eyecare and Laser Surgery** the charges for all medical services rendered and materials fees associated with glasses or contact lenses. In the event that I fail to pay the fees as agreed, I understand I will be responsible for all attorney fees, court costs, and collection fees that may result from my failure to pay, to which may be added prejudgment and/or post-judgment interest at the current legal rate.

3. I acknowledge receipt of this facility's **Notice of Privacy Practices**. (Available in printed form in our offices.) You may release my information to: (please write person's name and relationship to patient)
   _____

Patient Signature: _____ Date: _____

Parent or legal guardian if patient is under 18 years old

Consent for Treatment of a Minor: I, the undersigned, am the legal guardian of _____, a minor and do authorize and consent to medical examination and treatment by the physician and staff of **Lanter Eyecare and Laser Surgery** under the provisions of the laws in the State of Indiana. It is understood that this authorization is given in advance of any specific diagnosis, treatment or medical care being required but is given to provide authority and power to render care, which the aforementioned provider in the exercise of his/her best judgment may deem advisable. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that treatment will not be withheld if the undersigned cannot be reached. The parent or legal guardian who brings a minor to the office for treatment or examination shall be responsible for all bills incurred at that time if insurance coverage is not applicable.

Legal Guardian's Signature: _____ Date: _____

Lanter Eyecare and Laser Surgery

North: (317) 844-6269 815-7567 fax South: (317) 887-7777 887-7775 fax Castleton (317)598-2020 842-5084 fax
Earl E. Lanter, MD James E. Wilson, OD, FAAO Donald H. Hulsey, OD Allison L Nowak, OD, FAAO

FINANCIAL/OFFICE POLICIES

Thank you for choosing us as your eye care provider. We appreciate your confidence and trust. Payment for your care is considered part of your treatment program. If you have any questions regarding our financial policy, please call our office manager during business hours. The following is a statement of our policies that we require you to **read, initial and sign prior to any treatment**.

_____ All patients must complete our patient and insurance information sheets prior to seeing the doctor. If these forms are not completed, you may be asked to reschedule your appointment.

_____ We are happy to file your insurance claim directly with your insurance company. Our insurance claims are computerized to insure proper filing. If there have been changes to your insurance, it is your responsibility to keep us updated prior to your appointment. Please keep in mind that **it is your insurance contract, and we look to you for payment, not your insurance company**. **We require all co-payments and deductibles to be made at the time of service, without exception. You are obligated and responsible to pay your portion**. If you do not have insurance, we expect payment in full at the time of service.

_____ **Refractions**: All new patients and anyone seen on a yearly basis may require refraction as part of their comprehensive eye examination. A refraction may be medically necessary to treat refractive errors, adequately determine visual function, and verify whether serious underlying eye issues exist. Refractions are not a covered service for Medicare or most other medical insurance plans. Therefore, you will be responsible for paying the refraction fee. **This $50.00 fee is due at the conclusion of your visit.**

_____ **Dilation:** I hereby authorize the doctors of Lanter Eyecare and/or such assistants as may be designated by him/her to administer dilating eye drops in order to fully evaluate my ocular health. I have read the posted information concerning dilation. I may have a copy of the dilation information upon request.

_____ **Statement of Managed Care Responsibilities**: In order to accommodate the needs and requests of our patients, we have enrolled in numerous managed care programs and vision plans. While we are happy to provide this service, it is extremely difficult to keep track of all the individual requirements of each and every plan. Even within the same insurance company, the plans may differ depending on what type of contract your employer has negotiated. **Therefore, if you do not inform us of any pre-authorization requirement in your contract, and we subsequently treat you without the necessary authorization, we will have no choice but to bill you directly for the charges.**

_____ **Prescription refill requests** are handled during office hours by voicemail. Refill requests can take up to 48 hours to process. There is a $5.00 charge per lost prescription.

_____ **Medicare**: Our office is enrolled in the Medicare program, which means we have a signed contract with Medicare to accept assignment of Medicare benefits for our services. We will complete and submit your Medicare insurance form for you. Medicare will pay its share of the bill directly to us. You will be responsible for annual deductibles and co-payments.

_____ **Appointments and Cancellations**: Promptness is appreciated for all appointments. We require 24 hours notice if you need to cancel your appointment. Lanter EyeCare reserves the right to charge patients for missed appointments or appointments not cancelled 24 hours in advance. (We have voicemail after hours.) We often have requests for work-ins by other physicians or patients with sudden onset of symptoms. In order for our providers to deliver quality care, you will need to arrive 5-10 minutes prior to your scheduled time to allow adequate time to update your information. If you arrive twenty or more minutes late for your appointment, you may be asked to reschedule your appointment.

_____ **Medical Records Release Form Completion and Copying**: Request for copies of patient medical records will be subject to a fee as authorized by Indiana code 16-39-9. To insure quality reproduction and confidentiality, your records will be photocopied and mailed. You are responsible for postage charges. Facsimile is not permitted. Please allow 10 business days for distribution. There is a minimum $10.00 charge to complete forms for school, military, and insurance entities, and a $25.00 charge for disability or FMLA forms per occurrence.

_____ **Agreement to Financial and Office Policies**: I have read and thoroughly understand the financial policy stated above, and I agree to accept financial responsibility as described. I hereby agree to pay **Lanter EyeCare and Laser Surgery** the charges for all services rendered. All balances are due within 30 days of the statement date. A $27.50 administrative fee will be charged for all returned checks. A $10.00 administrative fee will be charged each month on past due balances. If collection proceedings become necessary, you are responsible for all collection costs including a 26% of balance collection agency fee, reasonable attorney fees, re-billing fees, court costs, and all collection costs.

Signature: _____ Date: _____
(Parent or legal guardian if patient is under 18 years old)