

# DR. DALE G. LERVICK AND ASSOCIATES

OPTOMETRY

DALE G. LERVICK, OD, FAAO

JASON JOST, OD

CARRIE M. BURLESON, OD

PATIENT INFORMATION

Mr.  Mrs.  Ms.  DR. \_\_\_\_\_ Date of birth \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ ZIP \_\_\_\_\_  
Home Phone (\_\_\_\_\_) \_\_\_\_\_ Social Security # \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Employer \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_\_  
Occupation \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? \_\_\_\_\_  
IF NOT REFERRED, HOW DID YOU CHOOSE OUR OFFICE FOR YOUR EYE CARE? (Please check the appropriate answer)  Relative  Another Dr.  Yellow Pages  Friend  Insurance list

BILLING INFORMATION

Person Responsible for account \_\_\_\_\_ Relationship \_\_\_\_\_  
Insurance:  Yes  No  VSP  Medicare  Blue Cross  Cigna  \_\_\_\_\_  
Policy holder/subscriber \_\_\_\_\_ Insured SSN \_\_\_\_\_ Date of birth \_\_\_\_\_  
Name of carrier or group \_\_\_\_\_ Identification # \_\_\_\_\_

### Insurance Release Authorization

I request that payment under the above insurance policy be made directly to Dr. Lervick for services provided. I authorize Dr. Lervick to release information to my insurance carrier required for covered benefits necessary for insurance processing. I understand that Dr. Lervick's office will file my insurance claim as a courtesy to me. I also understand that I am completely responsible for non-covered benefits or services and agree to pay any and all charges not covered by my insurance.

FINANCIAL POLICY

**PAYMENT TERMS:** We are happy to assist you in the filing of your insurance claim. If your insurance will not pay the anticipated amount, or your insurance pays you directly, we ask that you pay the balance. Office policy calls for payment at the time of service. If eyewear or contact lenses are to be ordered, a minimum 50% deposit is requested and the balance is due upon delivery. We accept cash, personal checks, Visa and MasterCard. A monthly rebilling fee of 1.5% is added to all accounts with unpaid balances after 30 days.

**I have read and agree to all the provisions of the office insurance billing and financial policy**

Signed \_\_\_\_\_ Date \_\_\_\_\_

PRIVACY POLICY

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy Practices. Our privacy notice provided to you describes how medical information about you may be used and disclosed and how you can get access to this information.

**I acknowledge that I have received a copy of Dale G. Lervick and Associates Notice of Privacy Practices**

Signed \_\_\_\_\_ Date \_\_\_\_\_