PATIENT REGISTRATION FORM

Lifetime Vision and Contact Lens Center - Dr. Gordon Culp
44345 Premiere Plaza, Suite 100; Ashburn, VA 20147

Patient's Name _____ **Date of Birth** _____
Last First MI

Address _____ **Social Sec. #** _____

City_____ **State** _____ **Zip** _____ **Employer** _____

Telephone (H) _____ **(W)** _____ **Marital Status:** S M W D

(Cell) _____ **(Other)** _____ **Name of Spouse** _____

Medical Insurance

Insurance Carrier_____
Subscriber _____
Relationship _____
Member ID# _____
Group# _____
Secondary Insurance: _____

Vision Care Insurance
(If different from medical insurance)

Insurance Carrier _____
Subscriber _____
Relationship _____
Member ID# _____
Group # _____
Miscellaneous _____

Insurance and Financial Policy Information, Agreement and Authorization

Lifetime Vision and Contact Lens Center (abbreviated as LVCC) accepts many, but not all insurance plans. LVCC is not responsible for referrals. Patients will receive an itemized statement for submission to insurance plans which LVCC does not accept. Payment is expected at the time of each visit. Returned checks will be subject to a $25 returned check fee. All patients must present complete insurance information at the time of service to be eligible for benefits through LVCC. Patients will notify LVCC of any changes to their personal or insurance information. Retroactive insurance claims cannot be submitted by LVCC. Statements sent to patients will be expected to be paid within 30 days of statement date. Unpaid statements will be placed with a collection agency or an attorney and subject to interest of 1.5% per month and to additional collection/attorney's fees. The patient is responsible for non-covered services and for charges denied by his/her insurance company for services not paid within 60 days.

I understand and agree to comply with this office financial policy.

I authorize LVCC to apply for benefits on my behalf for covered services rendered by LVCC. I request payments from my primary and secondary insurances to be made directly to LVCC. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim to the above named billing agent. I permit a copy of this authorization to be used in place of the original. In all insured assigned cases, the physician or supplier agrees to accept the charge determination of the insurance carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and deductible are based upon the coverage determination of the insurance carrier.

_____ _____
Signature of Patient/Guardian **Date**