Schulz Eye Care, Inc.
R. Michael Schulz, O.D.

Last Name____________________________________ Jr. Sr. III

First Name __________________________ Middle Int. ______

____
What name would you like the doctors and staff to call you?

Address ____

City ____

State __________ Zip ____________________________

Home Phone ____

Work Phone ____

Cell Phone ____

Fax # ____

Email ____
(Schulz Eye Care may send special offers/communication)

Social Security #__________-__________-__________

❏ Male ❏ Female Birth Date_____/_____/______

Marital Status: (please circle one)
Married Single Divorced Widowed Minor Other

Responsible Party Information: ❏ Spouse ❏ Parent

Name____

DOB ____

SS#____

Employment Status: (please circle one)
Full Time Not Employed Student Retired Homemaker

Employer____

Occupation ____

Referred By____

Insurance (vision)__________________________________

(medical) __________________________________

PLEASE READ AND SIGN

1. In the event that my account becomes overdue, I understand that I shall be liable for all collection charges including attorney's fees, as well as monthly interest, late fees, etc.

2. As a courtesy, Schulz Eye Care will submit claims on my behalf to my **primary insurance** (provided the Doctor has a contract with my insurance company). It is my responsiblity to submit claims to any second or third insurance, if applicable.

3. I understand that I am responsible to Schulz Eye Care for applicable co-payments, deductibles, and non-covered services remaining after my insurance has paid.

4. I understand that it is my responsibility as the patient to know and understand my insurance coverage. (Schulz Eye Care will try to assist me in receiving maximum benefits from my insurance.

NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT:

I have received a copy of the "Notice of Privacy Practices" for Schulz Eye Care written in plain language. This notice provides the uses and disclosures of my protected health information that may be used by this practice, my individual rights, how I may exercise these rights and the practice's legal duties with respect to my information. I understand this practice has the right to change the terms of it's "Notice of Privacy Practices", and to make changes regarding all protected health information resident at, or controlled by, this practice.

I authorize Schulz Eye Care to discuss my health/account information with the following person(s). Print the person(s) full name. (Please write N/A on line 1, 2, and 3 if you do not wish to have your personal information discussed with anyone.) If you wish to revoke this, you may do so at any time IN WRITING.

1. ______________________ 2. ______________________ 3. ______________________

Signature (Patient/Parent) ________________________________ Date: _____/_____/_____

Print Name: ________________________________ D.O.B. _____/_____/_____

Relationship to patient: ________________________ Social Security # _____-_____-_____
(if signed by a personal representative of patient)