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)